

***An exploration of empowerment amongst final-year
undergraduate nursing students while on
clinical placement in Ireland using
Social Domain Theory***

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Glossary of terms

Preceptor: In Ireland and consequently in this study the term preceptor refers to the registered nurse who supports the nursing student during his/her clinical placement.

“Each student is assigned a named preceptor, who is a registered nurse, during clinical practice placement to provide support and supervision”.

(An Bord Altranais, 2005, p. 42).

“Preceptors/nurses, who support students, should have completed a teaching and assessing course to enable them support, guide and assess students and assist them learn the practice of nursing”

(An Bord Altranais, 2005, p. 42).

Mentor: *“Mentorship in pre-registration nursing in the United Kingdom is provided by a trained nursing registrant who has undergone additional NMC approved preparation in the teaching and assessing of student nurses in practice. The registrant is referred to as ‘mentor’, who is responsible for organising, coordinating and assessing student learning in practice. Internationally a similar role is undertaken by a preceptor.*

(Black et al. 2014, p. 225)

In Ireland and in the context of this study the term mentor is not used, however the term ‘preceptor’ which is used throughout the thesis can be replaced with the term ‘mentor’ for a reader who is more familiar with the use of this term.

Peripartum hysterectomy: A peripartum hysterectomy is described as an operation to remove the uterus within six weeks of delivery (Government of Ireland, 2006).

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Declaration by candidate

I declare that this thesis is my own work and effort and that it has not been submitted anywhere for any award. Where other sources of information are used, they have been acknowledged.

Signature: _____

Date: _____

Abstract

This is an exploratory study of the factors that enhance or inhibit empowerment development during the clinical placement of final-year undergraduate nursing students in Ireland. Empowerment is a topical concept used not only in health care but also in business and education. However, few studies have looked at the impact of clinical placements on the empowerment of undergraduate nursing students. A qualitative design was employed using Layder's adaptive and social domain theories (2005; 2006). Focus group interviews were conducted with 43 (n=43) undergraduate nursing students in one college providing nursing education in Ireland. Interview data was analysed and findings suggest that preceptors are pivotal to nursing student empowerment. When preceptors were empowered in the clinical learning environment they radiated positive influences and positively influenced nursing student empowerment. In addition the concepts of inclusion, belonging, trust and respect were also factors in creating a supportive culture to nurture nursing students' empowerment. Conversely disempowerment occurred in ward areas that reflected a hierarchical culture that lacked respect and where nursing student socialisation was inhibited by feelings of powerlessness. Cultural influences, socialisation processes and positive preceptorship within the clinical learning environment combined with feelings of power/powerlessness impacted empowerment of nursing students in this study. Not all participants in this study had similar experiences, demonstrating that organisational and hospital culture had a considerable influence on the extent of empowerment and disempowerment experienced by the participants.

Chapter 1: Introduction

1.0 Introduction

Chapter 1 provides an introduction and context to the thesis through its discussion of historical context and the development of nursing as a profession and details the contribution of empowerment to health care.

Section 1.2, provides a brief outline of empowerment, including a definition this is revisited in section 2.3.1. The context for the study, and the historical background, are presented in section 1.2 as they are unique to Ireland and Irish nursing education. This context provides an important background to the study and its relevance and contribution to the study can be seen throughout the thesis. In this section, the details of how nursing evolved from the early 19th century are presented, together with the role of the religious orders and the changes that ensued in nursing education, culminating in a description of the current programme of nursing in Ireland. Section 1.2.3 provides a summary to this section. The following section (1.3) details the research aim, while 1.4 presents the research objectives for the study, and the research questions are presented in section 1.5. Section 1.6 presents a justification for the study. In section 1.6.1, clinical practice and experience are discussed as precursors to my interest in empowerment of nursing students. The significance of the Lourdes Hospital inquiry (Government of Ireland, 2006) and its relevance to this study is presented in section 1.6.2. Section 1.7 discusses empowerment and its history, relevance and contribution to nursing under the following headings: empowerment and quality of care (section 1.8.1) empowerment and personal meaning in nursing (section 1.7.2), the clinical learning environment and nursing (section 1.7.3), professional socialisation and culture (section 1.7.4) and finally empowerment and power (section 1.7.5). The final section of this chapter briefly describes the economic climate at the time of this study, thus providing further background to the study (section 1.8). A short reflective piece in section 1.9, gives voice to my role and contribution to the study. Section 1.10 provides details of the thesis structure and the chapter concludes with a chapter summary in section 1.11.

1.1 Outline and Definition of empowerment

For many years, the subject of empowerment has been of interest to diverse disciplines, ranging from health care, to education and business. Spreitzer and Doneson (2005) contend that up to 70% of organisations employ some kind of empowerment initiative, which demonstrates its importance to work environments. Internationally, in health care, empowerment has been the subject of many studies, and has been viewed as a desirable and positive concept in the personal and professional development of nursing staff (Kuokkanen & Leino-Kilpi, 2000; Wagner et al., 2010; MacPhee et al., 2011). However, despite some concept analyses (Skelton, 1994; Rodwell, 1996; Wagner et al., 2010), the meaning of empowerment remains unclear. For the purpose of this study, it was found that a working definition of empowerment was required to provide clarity and to avoid confusion with this complex concept. Following a review of the literature, a working definition of empowerment was developed. This definition is discussed in more detail in section 2.3, but is presented here in order to provide clarity of meaning.

“Empowerment is an inner strength and inner power transcending expected behaviours due to the importance and meaning that individuals derive from their work. It is a desirable and positive concept that incorporates energy and impetus to do good for oneself and others within a nursing context”.

This study explores empowerment amongst final year undergraduate nursing students in one college of higher education in Ireland using the above definition of empowerment drawn from the relevant literature.

1.2 Historical Background - developing the context for the study

History is important because it has relevance to who we are as a people and as a society. It also has a particular relevance to nursing (Hallett & Fealy, 2009). The work of Florence Nightingale (1820-1910) has been credited with transforming the world of nursing (Robins, 2000). However, Nightingale's world was very different from that of today. The qualities of a good nurse in her day were described as being associated with restraint, obedience and discipline (Robins,

2000). The trajectory from the time of Nightingale to the nursing environment of today, and how nurses are educated for practice, is important and relevant to this study on empowerment of undergraduate nursing students in the clinical learning environment. Such is the importance of culture and historical legacy, that the authors of one Irish study on the empowerment of qualified nurses described it as a major theme in their work (DoH & C/DCU, 2003). In order to set the scene for this study, the following section provides a brief history of Ireland's development in nursing and health care from the early 1900s to the present day.

In the early 1900s, in Ireland nursing was developing as a respectable and worthwhile profession (Robins, 2000). Training schools for nurses were developed to ensure that a body of nurses would be trained which would stand up to stringent scrutiny, with high moral standards. Florence Nightingale's legacy in late Victorian times was visible. In Ireland, these training schools were established by the religious orders such as the Sisters of Mercy and the Irish Sisters of Charity (Hensey, 1988). Therefore, it was the voluntary sector rather than the state-run institutions that were involved in developing the quality and status of nursing, and establishing the social standing of members of the nursing profession. The religious sector in Ireland also had precedent in running (primary and secondary levels) schools, and their involvement with education meant that they had the confidence of the people and society at large. As Robins (2000) explains, during this period (acknowledging the prevalence of class distinction) any association with the religious orders, whether in education or nursing, was tantamount to a stamp of approval. And so it became socially acceptable for those from a middle-class background to consider nursing as a career. Hospitals run by the religious orders had affiliations with those who were considered to be "distinguished" members of society. These individuals were members of the medical schools, benefactors and lay members of society from the influential classes, thus providing a further seal of distinction to nursing in Ireland (Robins, 2000).

However, during this period (the early 20th century), in spite of the progression of nursing as a more socially appealing profession, those in the medical profession and public health were concerned about the high rates of maternal and infant

mortality. In Britain, a similar debate ensued with the statutory regulation of midwifery being introduced in 1902 (Hensey, 1988; Robins, 2000). However, despite the fact that the country at this stage had not attained independence from Britain, these provisions were not extended to Ireland. New provisions on the regulation of midwives specifically excluded the recognition of Irish-trained midwives. Eventually, after growing pressure had been exerted from Ireland, the British government implemented the Midwives (Ireland) Act 1918 (Robins, 2000) – the first establishment of a central Midwives Board that would maintain a register of midwives and be involved in their training and development. This register meant that should a midwife's action justify removal from the register for the first time, this could now happen. In addition, the new legislation forbade anyone to describe herself as, or act as a midwife, unless she had received the necessary qualification to do so. Most important, it made it an offence for a woman to attend a childbirth unless under the direction of a doctor or unless she was a certified midwife. It is interesting to note that this unique independent status of the midwife practitioner dates back to this ruling. The relevance of this can also be seen in relation to the Lourdes Hospital Inquiry (Government of Ireland, 2006) discussed in section (1.6.2). In order to become a midwife during this period, a fee was charged to the trainee. This actually had the effect of making it impossible for those from working-class backgrounds to enter the profession. The fee charged by Holles Street Hospital, Dublin was £22 per annum, when the wages of a labourer were £50 per annum. Following the registration of midwives, the registration of other categories of nurses came in quick succession and separate bills were passed in 1919 (Robins, 2000). The Irish Act (1919) provided for the establishment of the General Nursing Council for Ireland. It consisted of 15 members, nine being nurses appointed by the chief secretary for Ireland, after consultation with nursing bodies, and six chosen after consultation with bodies with a special knowledge of the nursing and medical services (Robins, 2000).

Very quickly the new board governing midwives stipulated that training for midwifery should be six months, with exceptions for those who could prove they had experience (Robins, 2000). The Irish hospitals that were recognised were the Rotunda, Coombe and the National Maternity Hospitals in Dublin; Cork Lying-In Hospital and Cork Maternity Hospital; Bedford Row Hospital, Limerick; and the

Incorporated Maternity Hospital, Belfast. During the 1920s, the training period for midwifery was increased to six months for trained nurses and to one year for candidates without nurse training. At the end of the 1930s, the training period for those not already trained as general nurses was increased to 18 months (Hensey, 1988; Robins, 2000). During this period of development, ethical issues and disciplinary issues had also been addressed by the new board. This marked the start of nursing as a profession, since it was bound and responsible to the nursing board for practice. During this time, nurses were given badges on completion of their training, and this was to denote them as “nurses”, as well as in recognition of the training and education they had received. This custom has continued to the present day in Ireland, with graduating nurses from many hospitals receiving a hospital badge as well as their degree from the associated college.

At the same time, a similar reform was occurring with the General Nursing Council (Adult Nursing). They also were successful in implementing standards for the recruitment and retention of nurses into the profession. It is important to note that during this time (1922) onwards, Ireland had succeeded in gaining independence from Britain and the emergence of a new state coincided with the development of new emerging health system. The development of the welfare state did not occur in Ireland until the 1940s (Robins, 2000). Ireland, as an emerging new state with new found financial as well as political independence, was now faced with the problem of financing health in the new republic. In order to finance the running of the training colleges, it was accepted that nursing education would be left under the control of the religious orders. The nursing education centres, in order to be viable financially, required a substantial fee which also served to ensure that those who were selected for nursing in Ireland were from “good families” of middle income, and would continue to maintain the profession in the high standards it had set (Robins, 2000).

In the 1940s, despite the lack of state funds, Ireland appointed a new first minister for health for the new state (Dr Noel Browne), who embarked on a programme of development that would incorporate building new hospitals. This, in turn, required more nurses to staff them, and coincided with the tuberculosis epidemic and the emergence of regional sanatoria to cater for people with this infectious disease. A

Cork hospital known as St. Finbarr's was given permission by the nursing council to train male nurses exclusively. The syllabus was the same as that of female nurses, with the exception of the subject of gynaecology which was omitted (Robins, 2000). The religious orders may have deemed it to be unsuitable to instruct males on the subject of gynaecology. This may have been a reflection of society at large, or was perhaps, more poignantly, a reflection of the role and power of the religious influence on nursing and nurse education. However, it is clear that the religious orders had considerable influence on nursing education and practice until relatively recently (see section 1.6.2). O' Shea (2009) reported that many hospitals were situated close to convents, and that posts of seniority were typically held by the religious orders, thus furthering their influence to that of senior personnel within the hospitals and nurse education centres in Ireland.

1.2.1 Context and background of the nurse education programme in Ireland

As nursing evolved in response to the social need for a safe delivery of health care, so too did nursing education. However, in the 1950s according to Chavasse (2000) there was little awareness of nursing having a unique body of knowledge associated with it. The emphasis was for nurses to recognise symptoms and prevent deterioration, rather than being familiar with pathology of diseases and actively improving health. Lectures for nursing students during this time were delivered by consultants in an *ad hoc* way (Chavasse, 2000). Nursing students would practise nursing on the wards in the religious and voluntary hospitals around Ireland, augmenting their knowledge and skills. Some were paid a small salary during this time but most of the teachers on the wards, as well as some lay staff, were religious sisters. In 1957, Chavasse (2000) reported that the nursing board ruled that nursing education was to change and incorporate distinct periods of learning over three years. While students were learning nursing during the "block" periods, they were relieved of their duties on the wards. This was important as it was the first recognition of the contribution of the learners to the wards, and the need for them to be freed from nursing, thus prioritising learning. This system remained in place until the 1990s. Further changes occurred in the following decades, from the 1970s to the 2000s, bringing a more uniform and

coordinated programme across Europe, in line with EU directives. These directives strove to increase theoretical instruction and recognised the need to staff hospitals during the learning period. In order to achieve a goal of increased professionalism for the profession of nursing, and thereby free learners from the wards while receiving theoretical instruction, a move to higher level education was mooted; and the change was introduced in Ireland following the Commission on Nursing in the late 1990s (Government of Ireland, 1998; Chavasse, 2000).

It is important at the outset of this study to briefly reflect on the trajectory and development of nursing in Ireland, from the early 1900 until recent decades, as it sheds light on the esteem of the profession by the general public, as well as how nurses perceive the profession themselves. The following section details the programme structure as it stood at the time of the study.

1.2.2 Nursing Programme structure in Ireland

As nursing education progressed in 1987, the Irish Nursing Board (formerly An Bord Altranais and currently renamed Nursing and Midwifery Board Ireland (NMBI)) adopted a policy decision to move all nursing education into the higher education colleges. The first three year Diploma course started in Ireland in Galway in 1994. The syllabus was a compromise negotiated between the hospital, the college and the Nursing Board. Biological and social sciences were taught by university lecturers and completed during the first academic year; nursing studies were delivered by nurse tutors in study blocks over the three years; and undergraduate nursing students were to have supernumerary status. There was a 14-week rostered and paid service compulsory in the third year. Though this worked quite well for a number of years, in the late 1990s dissatisfaction and disquiet was rife among Irish nurses. Many qualified nurses were dissatisfied with their terms and conditions, the lack of employment opportunities available to them, and the general esteem in which the profession was held by the government (O'Shea, 2009). At this time, nurses voted for change and agreed to embark on strike action, which was an unprecedented move in Ireland. A Labour Court ruling averted this action, but recommended the setting up of a Commission on Nursing. The Government of Ireland report resulting from this commission was published (1998) and presented the most comprehensive review of nursing in Ireland.

This report reshaped Irish nursing/midwifery practice and education structures for decades to come (Corbally et al., 2007). As stated previously, a recommendation of the An Bord Altranais in 1987 was further endorsed in 1998 by a report (Government of Ireland, 1998) that supported the move of nurse education to universities and colleges thus enjoying equal status with that of other professions. As clinical practice is the linchpin for undergraduate nursing students, this exposure was maintained in the restructuring, ensuring that clinical learning environment placement continued to capture adequate learning opportunities, thus guaranteeing that the required levels of competencies were achieved for registration as a qualified nurse (NMBI, 2016). It continues to be the responsibility of the higher education authority and healthcare providers to meet these

requirements for preparation of the clinical learning environment. All educational placements for undergraduate nursing students in Ireland are subject to educational audit by the college of nursing (NMBI, 2016). The four-year BSc (Hons) Nursing degree began in 2002 and is a competency-based programme. The final (fourth) year consolidates clinical competence and students are part of the staff complement, rather than being supernumerary during this clinical internship. It was during this period that data collection for the present study took place. Initially this was paid employment (Government of Ireland, 1998) but since the recent economic downturn, payment has begun to be phased out. Nursing students during their clinical internship do three 12-week placements or four eight-week placements in medical or surgical wards.

Undergraduate nursing students are clinically educated and formally assessed by preceptors who are qualified nurses within the clinical learning environment who have completed an approved preceptorship programme (NMBI, 2016). The BSc (Hons) nursing students are also supported by clinical placement coordinators (CPCs) on a 1:10 ratio. CPCs are employed by health care institutions to coordinate the clinical placements. Each clinical site has a designated link lecturer responsible for visiting students on placement and liaising with the clinical staff. Ireland has retained a discipline-specific entry process in each of the following disciplines: general (adult), children's, psychiatric/mental health, intellectual disability, and midwifery nursing. A combination of academic exams and a clinical competency component forms the assessment of nursing students. Both the clinical and the academic assessment must be passed before the student nurse can be placed on the nursing register. Education and training takes place via the traditional trajectory of placements and theoretical input. Currently, students complete 81 weeks of clinical practice over four years, with 72 weeks of theoretical content. Clinical placement and theoretical content are divided over the four years. Each year, clinical practice is increased incrementally until the fourth year, when the student completes a clinical internship of 36 weeks' practice, following final year exams. Many studies and reviews of empowerment suggest that education is a precursor to empowerment or serves as a stimulus to empowerment (DoH & C/DCU, 2003; Bradbury-Jones et al., 2011; Smith, 2014). This present study is one of the first studies to explore empowerment with

undergraduate nursing students who will register with a degree in nursing on completion of the programme. This may or may not have an impact on the participants' empowerment.

Nursing in Ireland has had a unique trajectory, having evolved from being largely influenced by religious orders to its current position of being organised through the Health Service Executive (HSE), with the exception of private hospitals. Over the decades, many changes in practice have occurred, including how nurses are educated, selected for suitability to the profession, and assessed within the profession. Before embarking on this study, it was necessary to explore the background to nurse education and its development in Ireland, in order to explain the transition of nursing from the hospital-based "apprenticeship" model to university/college-based degree education.

In summary, it is also important to see how nursing in Ireland evolved with the development of the new state in 1922, and the unique role and influence the religious orders had in Ireland during this time. The significance of these changes in nursing education is such that they are referred to in the Lourdes Hospital inquiry, detailed in section 1.6.2. The following sections present the research aims (see section 1.3), objectives (see section 1.4) and research questions (see section 1.5) pertaining to the study. The subsequent section (1.6) provides a brief personal outline of how I became interested in the topic of empowerment, and specifically, why exploring empowerment in clinical practice of final year undergraduate nursing students in Ireland captured my interest.

1.3 Research aim

This study aims to explore final year undergraduate nursing students' experiences in clinical placement in relation to empowerment or disempowerment.

1.4 Research objectives

1. To explore the concept of empowerment.

2. To identify factors that enhance or inhibit empowerment

1.5 Research questions

The overall research questions asked in this study are:

1. What do nursing students understand by empowerment?
2. What are the factors that impact empowerment development during final clinical placement in undergraduate nursing students?

1.6 Outline of my personal interest in empowerment

My interest in empowerment was twofold; firstly, as a lecturer in nursing I became interested in how nursing students learned in the clinical learning environment during their nursing programme. As my interest in undergraduate nursing students' empowerment in clinical practice was growing, at a national and international level concerns regarding high-profile cases, and reports of negligence or poor standards of care, were emerging in the public domain (Wells & White, 2014). Secondly, an Irish case that captured my attention, within the context of undergraduate nursing education and nursing students, was the Lourdes Hospital Inquiry (Government of Ireland, 2006) (see section 1.6.2). The following section provides some detail on these topics as a justification for my growing interest in empowerment in nursing education, and the rationale for that interest. Firstly, I detail my personal experience of working with students, followed by a short description of the Lourdes Hospital Inquiry, (Government of Ireland, 2006) which served as an impetus for me to explore the empowerment of nursing students in the clinical learning environment.

1.6.1 Clinical Experience

The importance of clinical learning and nursing practice is undisputed (Levett-Jones & Lathlean, 2008; Koontz et al. 2010). Working as a paediatric nurse for many years, it became apparent to me that clinical placement experiences among students varied greatly. Some students appeared to flourish and learn from the

experience, while others claimed that they received little support and that learning was limited. In particular, their interest and motivation fluctuated, and depended on the ward and staff in question. From my observation of undergraduate nursing students, and in communicating with them, it became obvious that certain factors affected the learning experience and subsequent sense of empowerment among nursing students. How such students are empowered, and the extent to which they are empowered through practice, are important questions. However there is a lack of available empirical literature focusing on empowerment of undergraduate nursing students (Bradbury-Jones et al., 2007). According to Mackintosh (2006), socialisation into the nursing profession may have an impact on the empowerment process for undergraduate nursing students. Socialisation has in the past been studied by Davis (1975) and Melia (1987) with both authors recognising the importance of this stage of development and assimilation into the nursing profession. Socialisation and learning how to “fit into” nursing also has an impact on the professional socialisation of student nurses (Price, 2009). Empowerment of qualified nursing staff is a significant area of research, as is demonstrated in the volume of studies dedicated to the subject. Empowerment has been shown to affect both job satisfaction and improved quality care (Manojlovich & Laschinger, 2002), thus demonstrating its importance and value for nursing practice. More contemporary Irish literature (Scott et al., 2013) supported the importance of striving to empower qualified staff and ensure their visibility within organisations. Scott et al., (2013) cautioned that in the present climate of austerity in Ireland care needs to be taken that strategies are put in place that prioritise the empowerment of staff. However no such study has explored empowerment in Ireland in undergraduate education.

1.6.2 Lourdes Hospital inquiry

Contemporary health care, both internationally and nationally, has been subject to many high profile inquiries and investigations: The Francis Report (House of Commons, 2010) told a story of suffering and secrecy in health care delivered in culture of defensiveness and misguided loyalty in the United Kingdom. In Ireland, the Lourdes hospital Inquiry compiled by Judge Harding-Clark (Government of Ireland, 2006) detailed the circumstances that led to a situation where peripartum

hysterectomies were carried out unnecessarily. The Lourdes Hospital inquiry is focussed on the practice of Dr Neary and the midwives employed at the time within the hospital. However, it also takes a wider view into the education and socialisation of midwives in Ireland. While acknowledging the differences between midwives and nurses it is argued that this case is particularly relevant and useful for comparison to the education of nursing students. Within the Lourdes Hospital 188 peripartum hysterectomies were carried out (Government of Ireland, 2006) from 1974-1998. These statistics were radically different from the national average at the time (Government of Ireland, 2006). The ramifications for the women and families involved were life altering. Of the women who had hysterectomies, 41% were having their first or second baby and two women ended up childless as a result. Mathews and Scott (2008) contend that the findings of this report prompted important questions about power and nursing in Ireland. It is for this reason, and because it highlights the relationship between health care and the religious orders, and its impact on nursing education, that I became interested in this inquiry. Another frightening finding of the inquiry was that almost one quarter of the records pertaining to peripartum hysterectomies had been apparently systematically removed from the hospital. The inquiry concluded that these records had been *“Intentionally identified, traced and removed from the hospital”* (Government of Ireland, 2006, p. 147). However, the issue of staff knowing that something was going on but did not question it was a source for concern. Judge Maureen Harding-Clark referred to:

“the general sense that what happened should not have been tolerated and serious questions should have been asked long before October 1998”
(Government of Ireland, 2006, p. 316).

This raises the question of trying to understand a culture where questions were not asked or concerns not raised. Mathew and Scott (2008) suggest that many factors have contributed to this culture, including a strong authoritarian religious influence (see section 1.2.1) and a critical lack of auditing and peer review. However, the overall failure to question the actions of the consultant in charge of these women’s health remains to a certain extent unanswered. Another interesting fact highlighted in the report was that it was four midwives who were trained outside the Lourdes Hospital who brought about the action that led to the

Lourdes Hospital Inquiry. Mathews and Scott (2008) explored the power and empowerment of midwives to question the practices, and also question the loyalty of the staff to the obstetrician in question. They suggest that a postmodernist approach to understanding power is helpful (power and empowerment are discussed in relation to empowerment section 1.7.5 and section 5.3. In relation to the culture and practices in the Lourdes Hospital, Judge Harding-Clarke commented:

“To ask why or to comment was not part of everyday practice. To consider that things could change seemed unimaginable”
(Government of Ireland, 2006, p. 155).

The following passage, taken from the Lourdes Hospital report, illustrates the dilemma for staff that was presented within the Irish healthcare system at this time. Judge Harding-Clark (Government of Ireland, 2006) noted that, although intelligent and caring nursing practitioners when they had to question or required clarification, they were found to be deficient of the necessary skills and therefore failed to report to relevant authorities within the organisation the clinical dilemma that they found themselves in. During the course of the inquiry, it was found that a clinical tutor had concerns about the high level of hysterectomies being performed. Judge Harding-Clarke commented:

“We met a tutor who was articulate, well-educated and confident. The story is illustrative of hospital hierarchy in the past. Such a self-possessed woman could not bring her concerns to the appropriate persons in the organisation but felt she should seek advice from a church dignitary. She felt she was not supported by the senior hospital consultant or the hospital matron when she had the temerity to question the consultant. She expressed a very deep regret that she had followed her instincts and not done more to stop Dr Neary’s practices in 1980” (Government of Ireland, 2006, p. 180).

This case highlights that the perceived power of the consultant obstetrician together with the method of education and training of nurses in Ireland may have contributed to the culture described by Judge Harding-Clark (see section 1.7). This has particular relevance in the context of the present study exploring empowerment in the clinical learning environment, particularly bearing in mind how relatively recent this report is. In the Lourdes Hospital Inquiry, Judge

Harding-Clarke explains that many of the staff (clinical tutors) in the Lourdes Hospital were religious sisters. In Ireland at that time, obedience and a non-questioning approach to the religious sisters or to the clinical tutors (who were also religious sisters) was encouraged and expected (Government of Ireland, 2006). The nurses according to Judge Harding-Clarke (Government of Ireland, 2006, p.188):

“...operated in a very hierarchical atmosphere”

This is an important observation and one that is often cited in the nursing literature (Kuokkanen & Leino-Kilpi, 2000; Peltomaa et al., 2013). However, it was perhaps even more relevant in the Irish case due to the close relationship, in terms of the organisation of health care from its inception, with the religious orders, as detailed in section 1.2.1.

In summary, the above case highlights how historical legacy, power of consultants and hospital hierarchies, are vitally important contributors to nursing practice that influence practitioners having the confidence to question. Empowerment provides a forum to drive nurses forward questioning and critically considering each clinical scenario and patient (section 1.7.1 details the contribution of empowerment to quality nursing care). However, empowerment is a complex phenomenon that is multi-factorial and therefore elements such as historical legacy, education, power, hierarchies and management structures of hospitals are crucial in providing a backdrop for this study. Nursing empowerment, as can be seen in the example of the Lourdes Hospital Inquiry, is vital to providing safe nursing care. The following section provides a further discussion on the value of empowerment and its relevance and contribution to nursing.

1.7 Empowerment history, relevance and contribution to nursing

The roots of empowerment ideology are found in social action where empowerment was associated with attempts to increase the power of oppressed or powerless groups (Kuokkanen & Leino-Kilpi, 2001). In the 1970s, ethnic, sexual minorities and feminists adopted the ideology of empowerment to further

their cause in the promotion of equal rights (Kuokkanen & Leino-Kilpi 2000). In the next decade or two, empowerment began to appear in nursing literature as a means of liberation from oppressive power (Gibson, 1991; Fulton, 1997). More recently, it has been applied to education (Bradbury-Jones et al., 2010). International literature supports the benefits of an empowered nurse to the organisation (Laschinger et al., 2011), the patient (Laschinger *et al.*, 2010), and the individual nurse, in reducing job strain and increasing work satisfaction (Kluska et al., 2004). In Ireland, the government demonstrated a commitment to the concept of empowerment by commissioning a study of registered nurses (DoH & C/DCU, 2003). Data was gathered from 93 registered nurses and midwives identifying factors that affected their sense of empowerment. These factors included autonomy, education, skills, self-direction, and standing by professional decisions. This study is significant because it focuses on what empowerment means to the registered nurse, rather than adopting a management perspective.

Top-down management initiatives on empowerment have been introduced internationally, leading sometimes to opposition from staff, and generating uncertainty and confusion between organisational and psychological empowerment (Hewison & Stanton, 2003). Both management and individual perspectives on empowerment are discussed briefly in the following section, with more detail provided in section 2.5. The following sections outline the importance of empowered nurses to the following: the patient, the individual nurse (through the meaning of nursing and the socialisation into, and culture of, nursing), and finally the organisation or healthcare institution.

1.7.1 Empowerment and quality care

Perhaps one of the most compelling and appealing outcomes of an empowered nurse is the association with an improvement in patient care. In the current international climate, research in health care reports that nurses are frequently required to do more with fewer resources (Fletcher, 2006; Duchscher & Myrick, 2008). The challenges imposed on nurses to provide care in stressful clinical environments mean that they become more stressed and are at higher risk of emotional burnout and fatigue leading to absenteeism (Norman, 2013). These

stressors further impact retention and recruitment of nursing staff and, most importantly, the care of patients. The need to retain nurses while maintaining and improving standards of care is undeniable. However, quality care is dependent on empowered nurses' professionalism and quest for new knowledge in caring for the needs of their patients (Manojlovich, 2007). It is desirable that all nurses are empowered, to enable them to provide high quality care to their patients. Manojlovich & Laschinger (2007) report that empowered nursing staff provides better care for their patients and in the process experience increased job satisfaction. The relationship between job satisfaction and empowerment contributing to quality care is clear in nursing literature (Leggat et al., 2010).

It is clear from the research studies detailed above that nurse managers can draw some important guidance from this, as it reinforces the need to maintain and ensure the empowerment of the nursing staff. Kuokkanen and Leino-Kilpi (2000, p. 236) posit that:

“Empowerment is concerned with solutions rather than problems”.

Nursing is also a solution-focused pragmatic profession, where very often innovation and creativity are required on a daily basis. Empowerment therefore may be viewed as a tool for driving innovation and the quest for quality care in health care.

1.7.2 Empowerment and personal meaning in nursing

Many nurses enter nursing in the belief that the career they have chosen is worthwhile and meaningful. Providing help and care for those who need it in society is highly regarded. Meaning and impact are words that are synonymous with nursing. Whether “the meaning” derived from their work emerges through the delivery of care, through patient interaction or through a personal motivation, is unclear in the literature. According to Spreitzer (1995), psychological empowerment is clearly linked to meaning derived from work. Conversely, structural empowerment according to Laschinger, 2008 is associated with managerial interventions, aimed at increasing employee empowerment through

access to resources (information, support, resources and opportunities) within the organisation. Kuokkanen and Leino-Kilpi (2001) identified five factors that promote empowerment within individuals: moral principles, personal integrity, expertise, future orientation, and sociability.

Psychological and organisational factors affect how members of staff derive meaning from their work. Those who experience greater job satisfaction believe in their ability to influence the organisation in which they work, while the experience of stress has the effect of decreasing empowerment-promoting factors (Kuokkanen et al., 2007). Interestingly, Spreitzer et al. (1997) noted that those who report experiencing more meaning as a dimension of empowerment also report more job-related strain. It is possible that this may arise from an inability for such nursing staff to fulfil all of the needs of the patient.

Many researchers would support the view that without empowerment, work would have little or no meaning for employees (Spreitzer & Doneson, 2005; Casey et al., 2010). This is a significant factor in how staff and managers perceive the importance of environmental factors affecting the contribution made by staff to their organisation. Organisational structures shape the empowerment of staff members, while the removal of disempowering structures within an organisation may have a positive impact on the motivation within the workplace and consequent empowerment of staff. Therefore, the environment in which the nurse practises will have a considerable effect on that individual's sense of empowerment, and consequently on the meaning she/he derives, and the resultant impact on patient outcomes.

1.7.3 Clinical learning environments and empowerment

There have been dramatic changes in health care over the past 10 years, such as increased patient acuity, global nursing shortages, and changing demographics, place further stress on an already challenged healthcare system. In a review of the healthcare systems of 13 international countries, Aiken et al. (2012) identified that, where the practice environment was reported as being positive (i.e. managerial support for nursing care, good doctor-nurse relations, nurse

participation in decision-making, and organisational priorities on care quality), there was a significant association with patient satisfaction, quality of patient care and nursing outcomes. More specifically, hospitals with good work environments and adequate nurse staffing had improved outcomes for patients and nurses alike.

Nurses have always been challenged to provide care in a rapidly-changing environment. The increased pressures have resulted in greater problems with retaining staff, and reports of burn out and occupational stress (Ahmad & Oranye, 2010). However, according to Aiken et al. (2012), it is possible to provide quality care in a positive way, despite the global context of challenges. It is also possible that through empowerment, staff may contribute to the provision of quality care. Laschinger, a Canadian expert on empowerment, established the positive effect of empowerment on staff retention (Laschinger et al., 2009b), motivation, and job satisfaction (Almost & Laschinger, 2002). In addition, Laschinger et al. (2009a) recognised the perceived effectiveness of empowerment regarding retention of staff in nursing work environments. Norman et al. (2013) reinforced Nightingale's (1860/1969) contention that the environment in which we provide care is important to the health of both patients and nurses. Boychuk Ducshester and Cowin (2004), in a study of newly qualified graduates, found that unresolved stress from the clinical environment contributes to a lowering of self-esteem. Likewise, the DoH & C/DCU (2003) noted, in an Irish study, that a lack of time to provide care for patients contributes to the emotional exhaustion of nursing staff. Therefore, the importance of the environment and culture where care is provided needs to be prioritised in order to empower and support nursing staff to deliver quality care.

Pressures, experienced by existing staff, as a result of an overburdened healthcare system, need to be addressed. In a cross-sectional study of 10 European countries, Heinen et al. (2013) found that burnout was a factor that influenced staff who intended leaving the nursing profession. Healthcare leaders have sought to find solutions to these issues through re-engineering the healthcare environment to be more conducive to empowering staff to provide the best possible care for patients, thereby improving job-satisfaction and retention (Ahmad & Oranye, 2010). Empowerment studies reported on the relationship between job satisfaction and retention (Laschinger et al., 2004), and work-related

stress (Li et al., 2008). Job satisfaction is related to the ability of staff members to have a sense of meaning, autonomy, confidence, and impact from their work (Manojlovich & Laschinger, 2002). Having an empowered workforce is essential to the provision of care. It is therefore imperative that qualified nursing staff are supported in regaining and achieving empowerment through their work. Equally, from a management perspective empowerment of nursing staff is a factor that impacts recruitment and retention.

1.7.4 Professional socialisation and culture

During the age of Florence Nightingale, nurses were viewed as having a supplementary role, existing primarily to provide assistance to the doctor (Porter, 1991). Over the decades, with advances in practice and education, the expectation is that much has changed. However, Hollins Martin and Bull (2010), in a study of British midwives, found that midwives still acquiesce to hierarchical authority when there is a conflict of opinion. The quest for a professional title, with equal educational opportunities similar to other allied professions, is evident in the appetite within nursing for further education and through the growth and development of a variety of nursing programmes over recent years. The failure of the nursing profession to attain all of the prerequisites of a “professional” status, with a distinct body of knowledge and full autonomy, is well documented in the nursing literature (Porter, 1991; Ruddy, 1998; Scholes, 2008). In addition, Ruddy (1998) noted that the debate by nursing authors on the subject of professionalization has also in some way contributed to the controversy. It is possible that the quest for professional status highlights some of the inherent challenges evident within the profession that are manifest in oppressed group behaviours (Daiki, 2004), hierarchical power systems (Last & Fulbrook, 2003) and oppressive and restrictive clinical environments, as described by Duschester and Cowin (2004b). Davies’ (2004) analysis of government policy reveals the regard in which nursing is held at a constitutional level, and possibly exposes some of the underlying insecurities evident within the profession. Davies (2004, p. 238) argued that sentences cited in public policy documents such as “*nurses feel undervalued*” and again “*nurses consider themselves discriminated against*” demonstrated that this discrimination is something nurses “experience”, rather

than being a reality or fact. Davies (1995) suggested that this cultural devaluation of nursing has emerged for the following reasons: there are too few resources, nursing work remains under-analysed and poorly understood, too many changes arise through policy initiatives, and nurses are accorded little legitimacy and respect. Cultural ambiguity and devaluation therefore may be created through historical legacy and apparent in many different ways depending on one's perspective from either inside or outside the profession. Barrow et al. (2010) in a more recent study of study of doctors and nurses found that nurses did not view themselves as leaders and neither did doctors. The nurses power in the Barrow et al. (2010) study was confined to the direct room/ward/unit rather than part of the larger leadership/management culture. Schein (1990) suggests that culture is made up of physical structures and artefacts which are visible such as behaviour and language but also through less visible but perhaps more palpable values, assumptions and beliefs. It is this aspect of culture that is perhaps most potent.

The genesis of professional socialisation (of the role of the nurse) continues to contribute to the culture of nursing today. Howkins and Ewens (1999) stated that socialisation processes encompass values and norms as well as skills and behaviours. In addition McKimmand Wilkinson (2015) acknowledged the concept of professionalism is culturally bound and subject to change. Therefore, it is necessary to acknowledge the multiple contributing factors in the professional socialisation process of nursing students, and acknowledge them as influences on the culture that prevails in nursing. Dinmohammadi et al. (2013) and McKimm and Wilkinson (2015) supported the view that socialisation into nursing begins when one is a nursing student and continues in a haphazard and unpredictable fashion throughout one's career. Socialisation for nursing students is not an easy process but it is life-long. Duchscher and Cowin (2004) argued that efforts need to be made to ensure that the socialisation of new graduates into the profession is more supportive and less combative. However, few would deny that, despite it being a difficult transition into a culture and a profession with its own rules and regulations, it is a significant and important process (Dinmohammadi et al., 2013).

Gender too, according to Suominen et al. (1997), and more recently Fletcher (2006), plays a significant role in the way that power interplays in health care.

While Hedin (1986) suggested that male dominance in medicine (together with its ready acceptance by nurses) is an example of acquiescing to the oppressive environment, nurses as a collective group have not challenged the *status quo* by uniting to oppose male and medical dominance. Instead, nursing leaders and managers have demanded strict obedience and loyalty from the nurses (Mee, 2006). This emphasis on obedience and loyalty was perhaps heightened in Ireland, as evidenced by the historical influence of the religious orders in health and society and, in the last decade, by the Lourdes Hospital Inquiry. However, this phenomenon is not confined to Ireland and has international relevance, as Hollins Martin and Bull (2010) found in a contemporary British study of midwives that the response to the hospital authority was that of acquiescence. This domination of midwives was compounded by the fact that nurses worked long hours for little pay confirming the devaluation at both social and economic level of nursing.

The culture and belief systems that have been instilled in the nursing profession over the generations are significant contributors to today's culture. Howkins and Ewens (1999), confirmed earlier findings, noted that the socialization of nursing has at its centre students playing an active rather than a passive role. Mackintosh (2006, p. 954) suggested that the process of socialisation of undergraduate nursing students may lead to "*the development of a specific occupational personality*". The effect of this generic personality is a desensitisation of undergraduate nursing students towards the patients, in an attempt to become "like" registered staff. In a study of undergraduate early socialisation in nursing students, Price (2009) found that role models have a significant impact on the early socialisation process, and likewise, Livsey (2009) noted that role models in nursing literature also have an important function in this process. This emphasises the importance of the preceptors' role in nursing student education and has ramifications for the education of preceptors and qualified staff that support undergraduate nursing students on practice placement.

Preceptors as the primary role model have an important role in socialising nursing students into the profession. Hinds and Harley (2001) found that nursing students and new graduates are greatly influenced by the practices and opinions of senior

nurses. Price (2009) concurred with this and noted the significant impact of the preceptors on the socialisation of nursing students. However, the literature also suggests that not all nursing students experience this socialisation into the clinical area in a positive way. Levett-Jones and Lathlean (2008) and Chesser-Smyth and Long (2013) noted that poor attitudes of preceptors greatly impact the confidence of nursing students. These studies suggested that the environment into which nursing students are socialised is challenging and difficult, thus contributing to some of the difficulties they experience in clinical practice (Duchscher & Myrick, 2008).

Professional socialisation of nursing students into the nursing profession takes many forms. The prevailing culture, the predominantly female workforce and the lack of value that is seen to be attached to nursing by government are all contributory factors to the nursing environment. Power and powerlessness are important factors in these relationships and require examination within the context of nursing and nursing students' socialisation and professionalization. In order to provide context for this study, the following section discusses the relationship between power and empowerment.

1.7.5 Empowerment and power

Power is ever present and particularly evident in the clinical learning environment and nursing. Kuokkanen et al. (2007) suggested that power and empowerment are interwoven, and that in order to understand empowerment one needs also to understand power. Likewise, Bradbury-Jones et al. (2007) suggested that the difficulty in understanding power and its relationship to empowerment is that they both take on different forms in different contexts. Power may be viewed as an organisational tool or a personal attribute. It is also fluid and can change depending on the situation, which makes it difficult to describe and define.

It is evident, then, that power can be viewed from many perspectives and is part of all facets of life. Manojlovich (2007), for example, advocated viewing power from a historical, educational and nursing practice perspective, while Kuokkanen and Leino-Kilpi (2000) proposed that power and empowerment can be viewed from

three main perspectives: critical social theory, organisational and management theory, and psychological theory perspectives. In a contemporary analysis of power, Peltomaa et al. (2013, p. 586) stated that:

“Nursing power and empowered nurses go closely hand in hand”

This reinforces the importance of power in this discussion of empowerment and its importance in understanding the complexities of empowerment. Mathews and Scott (2008 p.131), on the other hand, advocated a postmodernist approach, drawing on the work of Foucault as being preferable to “*grand theories*” within a nursing perspective, as this is able to accommodate the fluid and dynamic, ever-changing concepts of power in a nursing context. From an emancipatory or critical social theory perspective, there are many reasons proposed in nursing literature for why nursing has traditionally been viewed as a profession that is dominated, oppressed, and lacking in power. Wuest (1994, p.357) suggested it is because historically, nursing was viewed as “*women’s occupation*” – a domestic role fulfilled by women. Educating nurses in hospitals also served to further contribute to the low status of the profession (Manojlovich, 2007). According to Rafael (1996), nurses view power as a masculine trait and, in a predominantly female profession, many are reluctant to access power. Manojlovich (2007) suggested that the reluctance of nurses to embrace their power and use it may contribute to their lack of control over their practice. Benner (1984) examined power in the provision of care for the patient, and refers to the transformative and healing effects power can have for the nurse and patient. Wuest (1994) suggested that nurses’ fail to appreciate their own knowledge gained through the provision of care and have focussed instead on the acquisition of power through professional statutes. It would therefore appear that power and powerlessness are inextricably linked and connected to care and nursing practice; and as acknowledged by Kuokkanen et al. (2007), the relationship between power and empowerment is complex. Thus, in order to examine the relevance and meaning of empowerment, power also has to be considered (Bradbury-Jones et al., 2008).

According to Kuokkanen and Leino-Kilpi (2001), power within the organisational context is the by-product of individual behaviours and relationships between

individuals. Bradbury-Jones et al. (2008) suggest that power is also shaped by its context. Hierarchical structures and an acknowledgement of a power legacy in healthcare have been an established presence in the nursing literature (Suominen et al., 1997; Bradbury-Jones et al., 2007). Interestingly, 'historical legacy' emerged as a key theme in an Irish study (DoH & C/DCU, 2003), and Kuokkanen and Leino-Kilpi (2000) suggested that empowerment (or lack of it) is associated with hierarchical and authoritarian organisations. While Gilbert (1995) noted that a lack of empowerment is directly related to the negative and authoritarian concept of power experienced by many nurses. Davies' (1995) stated that nurses frequently perceive their contribution as being "voiceless" leading one to question nurses' self-perception or self-esteem. Scott et al. (2013) in an Irish study stressed the importance of inclusion of nurses in strategic committees to give nurses a voice and to empower nurses within their organisations. This lack of voice or lack of power, that leaves nurses feeling powerless despite their important role in healthcare provision, has consequences at political, social and educational levels. An empowered workforce is necessary for compassionate high quality patient centred health care (DoH & C/DCU, 2003). Hierarchical power structures in healthcare stifle empowerment of staff and this has resultant implications for healthcare.

Lukes (2005) described power as having three dimensions: overt, covert and institutionalised. Institutionalised power is not maintained by single acts, but rather through socially-constructed norms of the institution. Therefore, those in subordinated positions become accustomed to, and socialised in, the ways of the institution. This can perhaps explain why nurses (DoH & C/DCU, 2003) do not voice their concerns, and feel that their voices are not listened to. Control and autonomy over work-related matters are important in nursing. These concepts are associated with job satisfaction, and are viewed as contributing to the overall efficacy of a nurse's role (Ellefsen & Hamilton, 2000). It would appear, then, that if nurses as subordinates neither have nor take control, their sense of job satisfaction can be adversely affected. Spreitzer (1995) maintained that factors such as self-esteem, impact, and job satisfaction are all part of empowerment. This further demonstrates the connection between power and empowerment, and the extent to which both concepts are inextricably linked.

From the individual or psychological perspective of an undergraduate nursing student, it is important to understand the hierarchical and sometimes fraught environment in which they will practice their nursing skills. Undergraduate nursing students need to be empowered to have a voice, and to feel that their contribution is being listened to in order to encourage and stimulate their feelings of self-worth and to acknowledge their important contribution. Kuokkanen et al. (2002) suggested that the use of empowerment to increase the power of subordinates is where the root of empowerment is traditionally embedded, while Decker and Shellenbarger (2012) advocated that empowerment and education are key contributors to the promotion of a healthy work environment for undergraduate nursing students. Laschinger et al. (2010b), in a study of new graduate nurses, found that empowering work environments lessen the effect of bullying. It is evident therefore, that power and empowerment can be viewed as having a close relationship, whether interdependent or connected.

1.8 Economic climate and context at time of study

Ireland's economic downturn is an important contextual factor in this study, as the nursing students who participated in the research began their nursing studies in 2008. Ireland, in that year, suffered a catastrophic economic decline which resulted in the government providing financial support to banks and in order to support the economic infrastructure in terms of health and social systems. Subsequently, health reform and cut backs were imposed which had many far reaching effects. Health is often considered the Cinderella of all government departments, and never more so than when a country is in crisis. In Ireland, waiting lists doubled, staff that could, opted for early retirement, and the introduction of a moratorium on recruitment meant that staff were not replaced, and that existing staff received pay cuts as well as an increase in their weekly working hours. Nurses are required to do more with less during this continuing crisis, and staff morale and hospital resources were challenged during this time. However, the impacts of such fiscal restraints are many, and this is one of the first studies of nursing students since this economic collapse in Ireland. This section

provides some background to, and statistical evidence of, this time in Ireland, as it is referred to later in Chapters 4 and 5.

As detailed previously (see section 1.2.2), health care in the Republic of Ireland is managed and delivered through HSE. The Department of Health and Children (DoH & C) provides policy for HSE implementation. There are 65 acute care hospitals in Ireland serving a population of 4.5 million people (Carney, 2010). An estimated €2 billion (3.2%) has been cut from the health budget since 2008, and a further €1.5 billion (2.4%) in cuts is scheduled from 2010 to 2013 (Condrón, 2011). These cutbacks were driven by both financial necessity and the need to reform and reshape the Irish healthcare system. Wren (2003) suggested that health reform was fuelled by recognition that it was underfunded and inequitable, while other problems associated with its organisation and delivery are also recognised. The challenges associated with the clinical environment within the Irish healthcare system were further compounded during this time by the introduction of the EU Working Time Directive (EWTD). This directive limits the working hours of doctors in hospitals to 48 hours per week (McGowan et al., 2013). This labour shortfall generated by the reduction in doctors' hours has been met with the development of advanced roles for nurses, such as advanced nurse practice. In addition to a shortage of doctors, further pressure on existing nursing staff has been created through an employment moratorium, salary cuts, increased working hours, incentivised retirement schemes and a restructuring of the hospital services (Wells & White, 2014). Wells and White (2014) argued that these changes would have profound consequences to the Irish healthcare service.

The changes detailed above have also occurred at a time of global nursing shortages that had an increased impact in Ireland as it coincided with the economic collapse and subsequent reforms and health cutbacks (Wells & White, 2014). In tandem with these economic and restructuring changes, there is heightened public and professional consciousness (Wells & White, 2014). Increased media reporting of medical negligence, coupled with quick and easy access to online medical knowledge via the internet, may contribute to today's culture, where the public's expectations of healthcare professionals are frequently unmet; creating an environment that is fraught and challenging for both the patient

and the nurse (McGowan et al., 2013). Patients are now demanding greater accountability and quality of care of healthcare professionals, and this in turn places greater pressure on them in order to meet those demands (McGowan et al., 2013).

1.9 The Researcher's voice

As an experienced paediatric and general (adult) nurse of 25 years, I have many years of clinical experience and working with nursing students. Currently, I am employed as a nursing lecturer in a higher education nursing school that is responsible for nursing student education. Previously, my role was to facilitate learning to nursing students as a clinical facilitator/coordinator within the clinical learning environment. This position, which is known in Ireland as a Clinical Placement Coordinator, was perhaps where my interest in empowerment of nursing students was galvanised. Therefore these roles served as an advantage and an impetus to do this study. In keeping with the methodological approach (section 3.4 & 3.5) of Social Domain and Adaptive Theory (Layder, 2005; 2006), I declared and played an active role from the beginning of the study (section 1.9 & section 3.13).

On embarking on this study, I decided to limit the exploration of empowerment to clinical practice, as this was where I had witnessed and experienced empowerment. In addition, I decided to limit the participants to one discipline of nursing, which was general (adult) nursing. As stated previously, in Ireland there are five specific disciplines in nursing detailed in section 1.2.2. The rationale for excluding other disciplines was they have different curricula and different placements and therefore it would prove difficult to analyse empowerment with so many variables. Final-year nursing students were selected, as their four years of experience would culminate in the final year placement. I then arranged to distance myself from the participants for the duration of the year of data collection (see section 3.9). In effect, for the year of the study I was not teaching the cohort involved in the research. It was important to acknowledge my experience (16 years as a clinical nurse and a further 10 years working and supporting nursing students) and to facilitate that knowledge transfer into this study of nursing student

empowerment in clinical practice. In Chapter 3, the philosophy of the study and methodology is discussed in full, though it is important to note from the start that I have declared an interest in, and passion for, nursing student education this is combined with experience in nursing practice and education.

1.10 Chapter summary

This chapter has provided a brief overview of how empowerment is an important and worthwhile concept to embrace in health care. The literature has indicated that empowerment has a positive impact on care and the patients' experience, nurses' sense of job satisfaction and ultimately staff retention. Power and empowerment however, are inextricably linked. Power impacts empowerment at a personal and organisational level and can be viewed from a critical social theory, an organisational, and finally as a psychological or individual perspective.

It is important, too, for nurses to have a healthy environment in which to practice good quality care. The clinical environment impacts care delivery as well as staff wellbeing. If the clinical environment is ignored, quality of care and job satisfaction will decrease. Personal meaning derived from nursing is an important contributor to the work environment. All of these factors contribute to the overall environment and culture of an organisation at macro and micro levels. The culture of organisations and hospitals affect the way in which care is provided, and how practitioners feel about the care they provide. Empowerment, therefore, may be viewed as an important factor that contributes to the overall health and wellbeing of an organisation and its employees. Following an outline of the thesis structure, the subsequent chapter reviewed seminal and current literature on empowerment and nurses/nursing students in a healthcare context.

1.11. Thesis Structure

In order to provide a clear outline of the thesis, an overview of each chapter is presented in this section detailing the main sections contained within each chapter.

Chapter 1

In this chapter, section 1.2, presents a definition of the term empowerment and describes the historical context and its influence on the development of nursing and nursing education which are important factors in the present study (section 1.2.1). The nursing programme structure is detailed in section 1.2.2. This is followed by section 1.3 that describes the research aims, objectives and research questions that the study is exploring. A justification of the study is presented in section 1.6, describing my professional career, followed by a discussion of the relevance and importance of the Lourdes Hospital Inquiry. This demonstrates the importance of empowerment's contribution in nursing and nursing education. A brief section 1.7 discusses the contribution of empowerment to nursing followed by section 1.8 which provides an overview of economic climate and context at the time of the study in Ireland, and section 1.9 presents a reflective section referred to as the 'the researcher's voice'. This section provides the reader with additional information regarding my thoughts and feelings at various stages throughout the study. The chapter concludes with a chapter summary in section 1.10 followed by an overview of the thesis structure in section 1.1.

Chapter 2

Chapter 2 presents a critical appraisal of the literature on empowerment and empowerment theory. Section 2.1 describes the process that was employed in searching for relevant literature. Section 2.2 provides the results of the literature search and section 2.3 presents a more in depth discussion on selecting a definition for empowerment. The literature is then discussed under the headings: organisational empowerment, psychological empowerment, mixed theoretical approaches to empowerment, critical social theory and empowerment, and finally empowerment and nursing students' literature. The chapter concludes with a chapter summary.

Chapter 3

Chapter 3 presents the underpinning philosophy and associated theoretical perspectives that are used in this study of nursing students' empowerment during final clinical placement. In section 3.4 Layder's Social Domain Theory is presented and Adaptive Theory (2006) is presented in section 3.5 together with a justification for its use in the present study. The use of Social Domain Theory in this study presents a theory that is capable of representing how nursing students describe empowerment during their final year clinical placement. As empowerment is a complex phenomenon, Layder's representation of the social world and its complexities can provide a broad base on which to frame an understanding of it. Layder's Adaptive Theory (2005) provides a flexible yet pragmatic approach to data gathering and analysis. Section 3.6 describes an overview of the research process, section 3.7 considers the ethical implications, section 3.8 describes the sample and section 3.9 provides rationale for the use of focus groups. Section 3.10 describes the data analysis in detail, with relevant examples given throughout. Section 3.11 discusses the use of NVivo and section 3.12 presents the changes that occurred during the study. Section 3.13 is assigned to describing my reflections throughout this part of the research process. The chapter concludes with a chapter summary (section 3.14).

Chapter 4

Chapter 4 presents the findings of the study, together with the main themes that emerged following the process (methodology) detailed in Chapter 3. These three themes contributed to nursing student empowerment in the context of the present study. Each theme is presented together with the relevant supporting quotations from participants in the focus groups. Relevant literature that was consulted during data analysis is discussed in relation to the development and description of the themes in this chapter in keeping with Layder's methodology (Social Domain Theory and Adaptive Theory 2005:2006). Each theme is presented with supportive findings and a theme summary captures the main elements of each theme. Section 4.4 provides a reflective insight into my thoughts and considerations and is followed by the final section (4.5) which provides a summary of the entire chapter.

Chapter 5

Chapter 5 presents a discussion of the findings of the present study drawing on additional empirical and theoretical literature. This chapter discusses the findings in relation to the relevant and seminal literature, and also considers the findings in relation to the theoretical literature, drawing on Layder's Social Domain Theory and Adaptive Theory (2005; 2006). Chapter 5 discusses the empowerment in clinical placement under the following headings: the contribution of culture to empowerment and disempowerment (section 5.1), preceptors influence on empowerment (section 5.2); incivility in the clinical learning environment (section 5.3); the impact of socialisation on empowerment (section 5.4) and the influence of power/ powerlessness (section 5.5). The clinical learning environment and context at the time of the study is discussed in section 5.6. Section 5.7 describes the findings of the study and explores the findings in relation to Layder's Social Domain and Adaptive Theory (2005: 2006). This chapter concludes with a chapter summary (section 5.8).

Chapter 6

The focus of Chapter 6 is to review the contribution of this piece of research in relation to the research questions and findings, and draws relevant conclusions and recommendations for practice. Firstly the focus of the study is revisited (section 6.0). Section 6.1 presents the limitations of the study and the importance of empowerments contribution in healthcare is reiterated (section 6.2). The key findings (section 6.3) are presented together with recommendations and recommended actions. The chapter concludes with a final chapter summary (section 6.4).

Chapter 2: Literature Review

2.0 Introduction and scope of the review

The previous chapter provided an overview of the contribution of empowerment to health care. This chapter describes the literature review process and reviews the available literature on empowerment and empowerment theory. Section 2.1 describes the process engaged for the literature review; section 2.2 provides the results of the literature search; a definition of empowerment is provided in section 2.3 followed by a discussion on empowerment and its relationship with power from a theoretical perspective (section 2.4). The theoretical approaches (section 2.5) of empowerment are divided into subsections entitled: organisational and management theories (section 2.5.1), psychological theories (section 2.5.2), critical social theory (section 2.5.3), mixed theoretical approaches (section 2.5.4) and nursing student studies on empowerment (section 2.5.5).

The initial aim of the literature review was to critically review all relevant literature on the subject of empowerment amongst undergraduate nursing students. However, due to the relative lack of material specifically associated with nursing students, the search was broadened to include qualified staff, thus providing the much-needed background and context to the subject. The focus of the review was to identify a gap in the literature on the subject of empowerment of nursing students, and it was found that there was an identified paucity of literature on whether or not nursing students were empowered in clinical practice, and what influenced this process. Internationally, empowerment of qualified staff is the focus of many studies in the following countries: Canada (Laschinger et al., 2011); America (Chandler, 1992); China (Cai et al., 2011); Finland (Kuokkanen et al., 2009); Australia (Leggat et al., 2010); Ireland (Casey et al., 2010) and Corbally et al., (2007). Contemporary research supports the view that an empowered nurse has favourable outcomes in terms of: improved patient care provision (Laschinger et al., 2014), benefits to the organisation of practice (Corbally et al., 2007) and personal benefits to the practitioner (Manojlovich, 2005).

2.1 Process for literature review

A critical review of the literature was undertaken using a systematic approach (Grant & Booth, 2009). Key words were searched in all databases from 2002 to 2015, as detailed in Table 1. The rationale for this was that in 1998, following the Commission on Nursing in Ireland, nurse education changed from diploma to degree entry for all nursing students in Ireland. It therefore seemed appropriate to use literature from this transitional period, though seminal articles prior to 2002 that were of particular value were included in the review. The Critical Appraisal Skills Programme or CASP (2013) guidelines were used to assess the suitability of quantitative and qualitative articles for inclusion in the review. A manual search of journals and publications was also carried out, and a review of references in published articles, journals, text books and publications was also performed. Grey literature, such as government reports and discussion papers, were also searched and included where relevant. Manual searches in libraries and public document archives were undertaken in order to complete these searches.

2.1.1 Inclusion and exclusion criteria

The literature search revealed a plethora of studies on empowerment. Much of the literature emanates from diverse ideologies such as psychology, sociology, feminism, radical politics and educational literature. Very little literature focused on empowerment of nursing students, and much of the literature that focussed on nursing students concentrates on empowerment in the academic, rather than the clinical setting. Since, the focus of this study was on empowerment in a clinical setting, literature that spanned the years 2002 to 2016 was included. Seminal studies from outside this period were also included if they were relevant to the topic and addressed empowerment from a unique perspective that was valuable to the review.

Inclusion Criteria

- Published and unpublished research reports, government reports, papers, discussion papers and empirical studies in the English language from 2002-2016.
- Research papers with a specific focus on empowerment and clinical placement with nursing students, staff nurses or managers.
- All study designs were included in the search.

Exclusion Criteria

- Published and unpublished research reports, government reports, papers, discussion papers and empirical studies in any other language other than the English language.
- Any published/unpublished research reports, government reports, papers, discussion papers and empirical studies before 2002 that are not empirical/seminal research articles or of unique value to the study.
- Empowerment studies of other groups of professionals other than nurses and nursing students.
- Empowerment studies whose focus was not nursing.

2.1.2 The Search strategy

The search strategies employed for this review concentrated on critically and systematically reviewing the literature on empowerment in nursing and health care, specifically by searching a wide range of online resources and databases and including: Academic Search, Complete, Cambridge Journals Online, Emerald Management Extra, Inform World, Nexis, ABI/Informal Global, Directory of Open Access, Nurimedia Journals, Blackwell Synergy, Cochrane Library, Medline, Psych INFO, Wiley Online, Cinahl, ERIC, Science Direct, Business Source Premier.

In addition, reference lists in retrieved publications were reviewed. The online resources and databases were searched using the search terms (see Table 1)

and the search was refined through the use of Boolean operators AND, and OR (Ely & Scott, 2007). The results of the literature search are identified in Table 2.

Manual searches of Spreitzer and Laschinger's websites (both of whom have written extensively on empowerment), and ProQuest Dissertations were also useful for gaining further insight into the topic of empowerment of nursing students in clinical practice. The majority of studies focused on empowerment and qualified staff, empowerment from a management perspective, or empowerment of nurses through patient care (Bradbury-Jones et al., 2011). Few studies dealt with nursing students and empowerment (Kennedy et al., 2015), and this research is an attempt to address the gap identified in the literature. Abstracts and/or full texts were reviewed prior to their inclusion or exclusion in the review. Table 1 details a list of search terms used and the combination of words and spellings aimed to capture all relevant published literature. Various combinations of terms were used in an effort to capture all the relevant published literature on the subject of empowerment.

Table 1: List of search terms used for literature search

Empowerment	Retention and empowerment	Bullying and empowerment
Power and empowerment	Psychological empowerment and health professional	Psychological empowerment and health practitioner
Psychological empowerment and healthcare worker	Psychological empowerment and clinical practitioner	Psychological empowerment and retention
Psychological empowerment and student nurses/nursing students	Structural empowerment and clinical practice	Structural empowerment and clinical placement
Structural empowerment and health professionals	Structural empowerment and health practitioners	Structural empowerment and healthcare workers
Structural empowerment and student nurses/nursing students	Organisational empowerment	Organisational empowerment and healthcare worker
Organisational empowerment and health practitioner	Organisational empowerment and clinical practitioner	Organisational empowerment and student nurses/nursing students
Organisational empowerment and clinical placement	Organisational empowerment and clinical practice	Organisational empowerment
Organisational empowerment and healthcare worker	Organisational empowerment and health practitioner	Organisational empowerment and clinical practitioner
Organisational empowerment and student nurses /nursing students	Organisational empowerment and clinical placement	Organisational empowerment and clinical practice

2.2 Results of literature search

The search strategy identified 1,548 published research papers from the databases searched. Abstracts and or full texts were screened to ensure they met the inclusion criteria. A high number of non-applicable papers resulted from the search terms used. Many of the studies focused on topics such as cultural diversity and ethnic groups and were of no relevance to this study. The quality of the remaining articles was assessed using the CASP (2013) guidelines for qualitative and quantitative studies. Any studies that were deemed to be of an inferior quality using the guidelines or those that did not meet the inclusion/exclusion criteria as outlined above were discarded. A total number of 62 studies, including reviews, were found to be of value and relevance to this review. These are considered in the following sections and compiled (see Table 3). This table indicates the main categories that emerged from a range of national and international studies, as follows: organisational empowerment, focusing on a management perspective of empowerment (12 articles); psychological empowerment (9 articles); mixed psychological and structural empowerment models (17 articles). The final category to emerge had a base in critical social theory and feminism (2 articles), and a further 8 articles focused on nursing students. In addition, 14 concept analyses/reviews were included. No studies appear to have explored empowerment from the perspective of context and historical legacy.

In Table 2, the reviewed literature is presented according to the type of study, namely: organisational theory studies; psychological theory studies; critical social theory studies; mixed theoretical approaches; studies on nursing students' empowerment; reviews and concept analyses; and government reports. Each study is presented from either a quantitative or qualitative approach, though the majority were found to explore empowerment from a quantitative perspective. In addition, the country of origin is included to highlight the fact that few studies have emerged from Europe, by comparison with those from America. Only three Irish studies are included in the review, thus indicating a lack of relevant Irish literature on empowerment.

Table 2: Literature reviewed according to type of study

Organisational Theory		
Researchers/Year	Sample size	Method and main findings
Laschinger et al. (2011) Canada	919	Quantitative Empowered leaders affects middle leaders which impacts on quality care
Laschinger et al. (2009) Canada	294	Quantitative Empowerment and engagement impact on work effectiveness
Laschinger (2008) Canada	234	Quantitative: work conditions mediate relationship between structural empowerment (SE) job satisfaction and quality care
Manojlovich and Laschinger (2007) Canada/US	332	Quantitative Empowerment creates positive work conditions
Laschinger (2008) Canada	234	Quantitative Structural Empowerment Impacts on job satisfaction and quality of care
Patrick and Laschinger (2006) Canada	84	Quantitative Empowerment impacts on job satisfaction and perceptions of organisational support
Laschinger and Finegan (2005) Canada	273	Quantitative SE impacts on organisational trust
Laschinger (2004) Canada	234	Quantitative
Manojlovich (2005) Canada	332	Quantitative SE impacts on job satisfaction
Ellefsen and Hamilton (2000) America/Norway	590/135	Quantitative Moderate levels of empowerment
Cai et al. (2011) China	238	Quantitative Empowerment impacts on job satisfaction and motivation
Zhong et al. (2009) China	598	Quantitative Significant relationship between empowerment and job satisfaction

Psychological Theory Studies		
Researchers/Year	Sample size	Method and main findings
Kuokkanen et al. (2009) Finland	199/193/ 103	Quantitative Change in organisations impacts on empowerment
Kuokkanen et al. (2007) Finland	1157/ 112	Quantitative High rate of work empowerment
Kuokkanen et al. (2002) Finland	416	Quantitative Nurses have positive image of own empowerment
Kuokkanen and Leino-Kilpi (2001) Finland	30	Quantitative Five principles of work empowerment as personal values
Istomina et al. (2011) Lithuania	218	Quantitative Education positively impacts on empowerment
Uner and Turan (2010) Turkey		Quantitative Moderate empowerment of nurses and physicians
Sparks (2011) America	451	Quantitative Younger nurses less empowered than older nurses
Spreitzer (1997) America		Quantitative Meaning and competence strong predictors of empowerment
Leggat et al. (2010) Australia	201	Quantitative Psychological Empowerment (PE) impacts on quality care
Critical Social Theory Studies		
Researchers/Year	Sample size	Method and main findings
Fulton (1997) England	16	Qualitative Four main themes of empowerment
Campbell (2003) America	32	Qualitative Academic staff and students found to be both empowered and disempowered

Mixed Theoretical Approach Studies		
Researchers/Year	Sample size	Method and main findings
Casey et al. (2010) Ireland	306	Quantitative Critical social empowerment strongest predictor of job satisfaction
Corbally et al. (2007) Ireland	93	Qualitative Education for practice is seen as important
Department of Health and Children & Dublin City University DoH & C/DCU, (2003) Ireland	4,050	Quantitative/qualitative Four factors impact on empowerment
Ahmad et al. (2010) England and Malaysia	556	Quantitative Different results in commitment and empowerment
Knol and van Linge (2009) The Netherlands	519	Quantitative SE and PE impact on innovative behaviours
Laschinger et al. (2009) Canada	3156	Quantitative PE impacts on organisational and psychological evaluations
Laschinger et al. (2010) Canada		Model Expanded model of empowerment including patient empowerment
Smith et al. (2010) Canada	117	Quantitative SE and PE impact on work incivility
Faulkner and Laschinger (2008) Canada	500	Quantitative SE and PE significant indicators of respect
Kluska et al. (2004) Canada	112	Quantitative Moderately empowered
Laschinger et al. (2003) Canada	185	Quantitative SE impact on PE and job satisfaction
Manojlovich and Laschinger (2002) Canada	347	Quantitative When SE and PE are increased so are patient outcomes
Laschinger et al. (2001) Canada	404	Quantitative Supports expanded model of empowerment PE and SE
Stewart et al. (2010) America	74	Quantitative High SE and PE
Baker et al. (2007) Latina, Mexico, New York and Indiana	46	Quantitative Empowerment is related to job satisfaction, age and years of employment
Li et al. (2008) China	178	Quantitative Moderate SE and PE
Ahn & Choi (2015) Korea	370	Quantitative In order to increase empowerment, educational strategies should be used

Nursing Student Studies		
Researchers/Year	Sample size	Method and main findings
Bradbury-Jones et al. (2011) UK	13	Qualitative Being valued impacts on empowerment of nursing students
Bradbury-Jones et al. (2010) UK	13	Qualitative Students are more empowered at end of course than at the beginning
Bradbury-Jones et al. (2007a) UK	66/20	Qualitative Similar levels of empowerment and disempowerment experienced by both groups
Bradbury-Jones et al. (2007b) UK	66	Qualitative Learning, power and team membership impact on students' empowerment
Ibrahim (2011) Egypt		Quantitative 50% of students empowered
Pearson (1998) New Zealand	6	Qualitative Greater awareness of preceptors to support students in gaining empowerment
Livsey (2009) America	243	Quantitative SE impacts on students behaviour
Levett-Jones and Lathlean (2008) Australia	18	Mixed methods Questionnaire and Interviews

Reviews and Analysis		
Researchers/Year	Sample size	Method and main findings
Kennedy et al. (2015) Literature review		Empowerment literature reviewed
Smith, N.J. (2014) Discussion paper		Commentary on empowerments contribution to nursing
Wagner et al. (2010) Literature review		SE and PE significantly associated with empowering environment
Bradbury-Jones et al. (2008) Discussion paper		Presents fourth theoretical approach on empowerment
Manjlovich (2007) Literature review		Reviews empowerment and historical context
Spreitzer (2005) Literature review		Empowerment literature reviewed
Leyshon (2002) Literature review		Empowerment if adopted could stimulate educators and students
Kuokkanen and Leino-Kilpi (2000) Literature review		Empowerment as a framework for nurses discussed
Lewis (2000) Concept analysis		Structural change is needed for empowerment to take place
Ryles (1999) Concept analysis		Empowerment and its relationship with mental health

Reviews and Analysis (continued)		
Researchers/Year	Sample size	Method and main findings
Rodwell (1996) Concept analysis		Model of empowerment presented
Roberts and Chandler (1996) Review		Creating an empowering environment will require change in teaching methodologies
Skelton (1994) Review		Distinguishes between empowerment of staff and organisation
Gibson (1991) Review		Literature on empowerment reviewed
Thomas and Velthouse (1990) Discussion		Four cognitions associated with empowerment are presented

The studies identified in Table 2 are described in detail in this literature review using the categories provided in the table under the heading “Type of study”. The literature review identified a number of challenges – principally, the lack of consensus of a definition for empowerment, coupled with a lack of agreement on a framework of empowerment. Firstly the lack of consensus on what empowerment is or does, makes it difficult to interpret research results. Despite concept analyses on empowerment (Gibson, 1991; Skelton, 1994; Rodwell, 1996), there remains a lack of agreement on a coherent view of what it means to be “empowered” (Kuokkanen & Leino-Kilpi, 2000). The following section details emerging definitions of empowerment from the nursing literature.

2.3 Defining empowerment

Firstly, empowerment as a concept needs to be defined, in order to aid clarity and further the discussion on how or what empowerment is, and the contribution it can make to health care. Empowerment is an abstract concept that is often used and often misunderstood Gibson (1991), and Kuokkanen and Leino-Kilpi (2000). Gibson (1991, p. 335) suggests,

“it is difficult to define and easier to understand by its absence”.

Rappoport (1984) stated that empowerment is like obscenity although we may not know what it is however we know when we have seen it. Kieffer (1984) and Rappoport (1984) were among the first to describe empowerment as a development process. The word “empower” conveys an impression of action and dynamism, and is derived from a Latin verb *potēre*, meaning to be able. Kieffer (1984) explained the core components of empowerment as being: self-identity, extensive apprehension and reflection of one’s environment and social intercourse. Gibson (1991) described it as a transactional process involving the individual and the environment. Conger and Kanungo (1988) developed the interpretation of empowerment by broadening it. According to them, empowerment is generated through the individual’s own psyche, and not solely through organisational structures, as Kanter (1993) suggested. Conger (1989, p.118) describes empowerment as:

“the act of strengthening an individual’s belief in his or her sense of effectiveness”.

Empowerment, according to Chandler (1992, p. 66) means to “*enable to act*”, and “*enabling individuals to feel effective so they can successfully execute their jobs*”. Therefore, at the very minimum, empowerment provides an impetus for action, or appears to propel action. Rodwell (1996) viewed empowerment as a transference of power, and an integral part of self-esteem and respect for self and others. Thomas and Velthouse (1990) suggested that power can create a dynamism that propels empowered individuals and organisations. This is seen as a cyclical process where motivation and risk-taking are core to the concept of empowerment (Kuokkanen & Leino-Kilpi, 2000). While, Rodwell (1996) noted that empowerment is both a process and an outcome, as the concept is dynamic and subject to constant change. It is also important to note that an individual’s level of empowerment is therefore not a constant, and is subject to fluctuations and changes. This would suggest that any exploration of empowerment as a concept needs to be cognisant of the fluid nature of the phenomenon.

Chavasse (1992) described empowerment as a concept that emerges from valuing others, and argues that it is not possible to value others unless one first

values oneself. Perhaps a more comprehensive definition of empowerment is provided by Hokanson-Hawks (1992), explained it as an interpersonal process in which educators provide tools and an environment that are enabling and conducive to increasing autonomy and decision-making. Hokanson-Hawks (1992), in her analysis of empowerment for nursing education, noted that the following factors are necessary if empowerment is to occur:

- 1.Nurturing and caring environment
- 2.Acceptance of student and mutual respect
- 3.Common purpose
- 4.Commitment to the process

Bradbury-Jones et al. (2010) would appear to support Hokanson-Hawks (1992), in suggesting that empowerment is concerned with facilitating students to reach their full potential, and advocated empowerment as a method of releasing that potential. Rodwell (1996) argued that there is a major role for empowerment in nursing, but suggested that nurses need to cast aside traditional training and education methods that reward conformity and stifle creativity, in order to foster empowerment. However, not all literature on empowerment is favourable. Leyshon (2002) questioned if empowerment is an unrealistic expectation of nurse education, and suggested that the literature on empowerment is not sufficiently self-critical. Corbally et al. (2007) caution that not all empowerment is “*genuine*” (p.170), as sometimes empowerment is encouraged by management to further a different agenda, leaving the workforce feeling disillusioned and confused. Despite advocating more censure to the nursing literature on empowerment, Leyshon (2002) concedes that not all ideas on empowerment should be completely rejected. This would suggest that there is some common ground among theorists and scholars on the essence of empowerment; but it is also important to note there are differences.

2.3.1 Definition of empowerment for this study

Empowerment is a complex and nebulous concept and has been the source of much theorising (Bradbury-Jones et. al, 2008). Both Chandler’s (1992) and

Kuokkanen and Leino-Kilpi's (2000) understanding of empowerment infers that empowerment can be given, traded, acquiesced or acquired. This understanding of the concept may affect how we understand and conceptualise empowerment. Different perspectives on empowerment in the literature may contribute to a lack of clarity of the topic. Therefore a working definition for this study was developed following extensive review of the literature in order to provide clarity at the outset:

“Empowerment is an inner strength and inner power transcending expected behaviours due to the importance and meaning that individuals derive from their work. It is a desirable and positive concept that incorporates energy and impetus to do good for oneself and others within a nursing context”.

In summary, it is widely accepted that the lack of objectivity associated with empowerment leads to ambiguity (Kuokkanen & Leino-Kilpi, 2000). The influences of the individual personality, life experience, organisational culture, and dynamics all contribute to a multifaceted concept (Bradbury-Jones et al., 2008). Whether empowerment is viewed from a top-down approach (management) or a bottom-up approach alters its appearance (Corbally et al., 2007), and so empowerment needs to be viewed from many perspectives, in order for it to be comprehended fully, rather than from a single stance. It is clear, from the review of definitions found in the literature that a common and accepted definition of empowerment does not exist. This in itself may contribute to the enigma that is empowerment, so in the interests of clarity for the purposes of this study, a definition of empowerment has been provided in this section (above). In order to fully understand empowerment, it is necessary to discuss power and its relationship to empowerment. The following section details power and empowerment, and discusses the relationship between each of these concepts.

2.4 Empowerment and power

Chandler (1992) is among the first to describe the process of empowerment in nursing, and notably distinguishes between power and empowerment. Corbally (1992) differentiates between empowerment which she suggested enables one to act, whereas power is associated with control, influence or domination. Empowerment encapsulates an element of power: power to propel action, power

to implement action, and power to empower. Kuokkanen and Leino-Kilpi's (2000) differentiation of power and empowerment is not dissimilar to Chandler's (1992), when they contend that the difference between power and empowerment is that power is the ability to get things done, while empowerment is the opportunity to take action that will generate positive results. It is clear that, in order to be empowered, one needs to know where the power lies, and how to put it into operation. Suominen et al. (1997, p.188) stressed the omnipresence of power in nursing in "*every nursing circumstance*", and its association with culture and that of the nurse patient relationship.

For Benner (1984), power involves caring practices employed by nurses that may be useful to empower patients. Benner (1984) contends that the power used in caring is a transformative and healing power. This suggests that nurses can use their personal power to empower patients. Kanter (1993) viewed power as a stepping stone to empowerment, and sees empowerment as emanating from satisfactory social structures that allow employees to be satisfied and effective. Conversely, Chandler (1992) suggested that empowerment is evolved from relationships and not just control, authority and influence. Powerless nurses are ineffective, according to Page (2005), who acknowledged the need for nurses to be capable of mediating with others on behalf of the patient, as well as the need to influence both the patient and other members of the healthcare team. Powerless nurses suffer from burn out (Manojlovich & Laschinger, 2002), and this may contribute to poorer patient outcomes (Manojlovich & DeCicco, 2007). In a separate study, Manojlovich (2007) noted that, while powerless nurses are ineffective, those who are empowered benefit the patient. Lack of nursing power, according to Manojlovich and DeCicco (2007), impacts patient care and contributes to poorer patient outcomes. This would suggest that there appears to be a relationship between power and empowerment, with power being an essential component of empowerment. As can be seen from the above studies, the patients of powerless nurses appear to have poorer outcomes. However, powerlessness and disempowerment have not been explored to investigate whether the converse is true, and if a powerless nurse is a disempowered nurse. According to Manojlovich (2007), nurses need power in order to assert influence over an individual (patient/physician), a group (other healthcare professionals), an

organisation or a country, through policy. However, others have noted a societal reluctance to discuss power (Kanter, 1979).

Spratley et al. (2000) suggested that this may be because 95% of nurses are female, and Rafael (1996) noted that power as a concept or an attribute is associated with masculinity, and therefore threatens the view of nurses as carers. Kuokkanen and Leino-Kilpi (2000) suggested that power in nursing is connected with negative connotations because it is often associated with hierarchical, oppressive types of management. The key tools of power generation, according to Kuokkanen and Leino-Kilpi (2000), are the generation of opportunities, effective information and support within an organisation.

Gore (1992) argued that power as a component of empowerment should not be reduced to a context of dualism: powerful versus powerless, or dominant versus subordinate, and suggests that it is naïve to view power as a construct, a “thing” that exists and can be given or bestowed upon students. Gore (1992) favoured Foucault’s (1979) theory that power is constructed and reconstructed through relationships and interactions at an individual/micro level of human existence. Foucault’s theory of power proposed a model of power where it is not a fixed commodity but rather fluid, as its presence or absence may fluctuate. He argued that the critical theory view of power as a repressive force is too narrow and does not capture the productive aspect of power. Further, he saw power and knowledge as being very closely aligned, with power producing knowledge, and thereby altering the balance of power in health care. He also suggested that power should be studied from the bottom up, unlike in organisational/management theory, where it is advocated that power be viewed as a top-down phenomenon. Gilbert (2003) argued that power needs to be viewed in the way it penetrates life, which acknowledges the variety of ways nurses, for example, can be powerless or powerful, depending on the situation.

Foucault (1979) divided power into two types: disciplinary power and knowledge/power relationships. Disciplinary power is concerned with the development of the “disciplines”, which standardise behaviour and ensures that all those involved in the discipline act, speak and behave in a similar way. This,

according to Foucault (1980) is known as *docility-utility* and refers to a way of controlling how another person operates (Bradbury-Jones et al., 2008). Disciplinary power is exercised in three ways: hierarchical observation, normalising judgement, and the examination.

Hierarchical observation is how individuals within a profession are observed or subject to a constant “gaze” (Gilbert, 1995). With hierarchical observation, the nurse is aware or sometimes unaware of the “gaze”. Nursing documentation and records are an example of how the “gaze” can be indiscreet or silent (Foucault, 1990). The patient is another example of how the work of the nurse is being “supervised”, and patient empowerment is another example, through policy, of how this is further supported from organisational hierarchy. Perhaps the most pertinent example of how disciplinary power operates within the hierarchical observation is when nurses report other nurses to the disciplinary practice committees, on matters of fitness to practice.

Normalising judgement describes how what we perceive as normal behaviour has become the “norm” in a process of comparison with other behaviours (Hui & Stickley, 2007). Normalising judgement is like disciplinary power: it is not unidirectional and does not run from the top down. Bradbury-Jones et al. (2008) described how, when nurses are forming normalising judgments of patients, they themselves become the subject of other nurses who are forming normalising judgements of them, and so it continues. Foucault (1980) described this as *technologies of self*, whereby individuals can go through a number of *operations*, and monitor and censor their own behaviour in relation to other behaviour that they are surrounded by. This may have positive effects for the profession by improving standards, as the “ideal nurse” may be held up for scrutiny. However, it should also be clear that it is actually a form of discreet power in operation (Bradbury-Jones et al., 2008). Empowering nurses may also alert nurses to the forms of power and normalising judgement that take place under the guise of benign practices, such as reflective practice or clinical supervision (Bradbury-Jones et al., 2008).

The examination is a form of disciplinary power, and is comprised of a combination of hierarchical observation and normalising judgement. According to Foucault (1990), this can be a clinical examination of a patient, or an examination of nursing students. When a patient is examined by a nurse, it is a combination of normalising judgements and hierarchical observation that contributes to a decision. A positive example of the examination provided in Bradbury-Jones et al. (2008) is the examination of pre-registration students into the profession of nursing, where the “examiners” are gatekeepers to the profession, and a competency and confidence in the profession is maintained through the use of the “gaze” in assessing competence. Leyshon (2002) provided an example of how powerful the student may also be in this situation as he/she disrupts the class, thus using power in a negative way to interfere with the transfer of knowledge and learning.

In summary, empowerment and power are inextricably linked and the symbiotic relationship that exists between them needs to be understood in order to understand empowerment. Powerlessness and disempowerment do not feature in the literature and warrant further research to investigate if a relationship exists. The reluctance of nurses to embrace their “personal” power, that is exercised through caring and maintaining relationships, is not acknowledged by nurses. The societal or historical reluctance to assert power as a profession in nursing is a legacy that needs to be addressed. Nurses need to embrace their “power” in order to perform the art of nursing, and also to be cognisant of what is required and what changes need to occur in order to empower patients. In the following section, empowerment is viewed from an organisational, psychological, critical social theory, mixed and nursing student perspective, to demonstrate the many different approaches used to view empowerment.

2.5 Theoretical approaches to empowerment

Several studies explicated theoretical approaches to empowerment. For some, empowerment is an organisational tool used to the organisation’s advantage, and can be fostered by management in order to reap the benefits of an empowered workforce. For others, it is an individual characteristic shaped and moulded by the

individual's experience. Kuokkanen and Leino-Kilpi (2000) suggested that empowerment can be viewed in three main ways (1-3, below), and for the purpose of this review, and in keeping with the purpose of this study, two further categories have been added to reflect literature that uses a mixed approach (organisational and psychological) plus literature on nursing students.

1. Organisational and management theories.
2. Psychological theories.
3. Critical social theory studies.
4. Mixed theoretical approaches to empowerment.
5. Nursing student studies on empowerment.

2.5.1 Organisational theory studies

Organisational empowerment is a well-researched topic within the management and business arena. Much of the research emanates from North America, in the work of Laschinger, a Canadian expert on empowerment (organisational empowerment). Laschinger's work is based on the work of Kanter. Kanter, drawing on her experience in industry, understands empowerment as being related to the structure and organisation of the work environment. This stems from her award-winning ethnographic study *Men and Women of the Corporation* (Kanter, 1977 & 1993), study. This study was conducted at a time when women were beginning to enter the workforce. It chronicles how their progress was impeded by their lack of access to power, hence the development of Kanter's theory (1977:1993). Kanter's (1993) theory stated that access to power, information, support, opportunities and resources creates an empowering workforce and environment. Many studies have used Kanter's model to explore and measure empowerment, including Chandler (1992), Laschinger et al. (1996) and Laschinger (2008).

Laschinger's (2008) study conducted in Canada, where the Conditions of Work Effectiveness Questionnaire (CWEQ) was used with 234 nursing staff. This study used a predictive, non-experimental design to test if structural empowerment affects the practice environment, work satisfaction and patient care. Findings

indicate that the environs of professional practice mediate the relationship between structural empowerment, job satisfaction and nurse-assessed patient care. However, many of Laschinger's studies found that nurses were "*moderately empowered*", thus leaving questions unanswered as to how this empowerment occurred (Corbally et al., 2007, p.170).

Laschinger et al. (2011) surveyed senior managers (SM), middle managers (MM), front-line managers (FLM) and practice leaders (PL) in 28 academic health centres and 38 community hospitals in Canada. The objective of the survey was to explore whether or not nurse leaders who are empowered due to high levels of transformational leadership, would promote improved quality of care, and reduce intentions to leave within their organisation. The sample size was 231 MMs and 788 FLMs. The response rate was 60.2% and 53.9% respectively. Structural empowerment was measured using the CWEQ-11 questionnaire. Confirmatory factor analysis on CWEQ-11 revealed that CWEQ-11 has evidence of construct validity (Laschinger et al., 2001), and Cronbach's alpha reliabilities range from 0.79-0.82. Both groups of managers (MMs and FLMs) felt they did not have access to resources required for their jobs. It is interesting to note that the size of the negative effect of perceived organisational support on intentions to leave was larger in the MM group ($\beta = -0.31$) than in the FLM group ($\beta = -0.19$). This would suggest that there are other factors contributing to the FLMs' decision to remain on in their jobs that were not captured in the study (Laschinger et al., 2011). It is possible that FLMs' interaction with patients, or empowerment derived from patient interaction, may have been a factor. It is interesting to note that Chandler's seminal study (1992) found that patient interaction is a source of empowerment. Patient interaction is an unexplored facet of empowerment. It is possible that other contributing factors, such as experience and patient contact may contribute to nurses' empowerment Chandler (1992) noted, in her study of staff nurses that while empowerment is contingent on information, support opportunities, knowledge and resources – a critical component is to be found in interpersonal relationships. Empowerment does not solely emanate from organisational structures and those in authority, but rather through "*giving to the patient, the family and the physician*" (Chandler, 1992, p. 69). A limitation of Laschinger et al. (2011) is that these factors are not captured in the study.

It is clear that nurse leaders play an important role in staff management and staff leadership, which in turn has many benefits for staff and patients. Leadership in Manojlovich's (2005) study in America is seen to be a moderator between structural empowerment and self-efficacy; self-efficacy and empowerment; empowerment and professional practice; and self-efficacy and professional practice behaviours. Structural empowerment was measured using CWEQ-11; self-efficacy was measured using the caring self-efficacy scale (CES); nursing leadership was measured using the managers' activity scale (MAS); and professional practice was measured using the nursing activity scale (NAS). Results show a significant relationship between structural empowerment and self-efficacy when leadership is perceived as strong, but not when leadership is perceived as weak. This not only demonstrates that social structures must be in place for empowerment to happen, but also shows that strong nursing leadership enhances this relationship (Manojlovich, 2005). The hypothesis is not supported in the findings in terms of the posited relationship between SE and self-efficacy. This is contrary to earlier research performed by Laschinger and Shamian (1994) that suggested a relationship existed between the two variables (structural empowerment and self-efficacy). The most compelling findings from Manojlovich's (2005) study are that structural empowerment contributes to more professional practice behaviours through self-efficacy in the presence of strong nursing leadership. Nasiripour and Siadati (2011) supported Manojlovich (2005) findings when they found, in an Iranian study of 292 registered nurses, that management and leadership strategies employed in the hospitals impacted nurses' sense of empowerment. Specifically, workload, respect, access to information and having a voice in hospital-related decisions impacted nurses' effectiveness and empowerment. These findings would support the idea that the workplace environment and leadership positively impacts staff and their performance. A limitation of these studies is that few have looked at empowerment from a broader perspective to incorporate the impact of the clinical environment on empowerment.

In order to further explore the benefits of the empowerment model, Manojlovich and Laschinger (2007) tested a work-life model in America and Canada, stating that managers who empower employees are likely to be viewed as trustworthy and treat their employees justly. This model is based on Kanter's model that

offers a framework for enabling nurses to accomplish their work in a meaningful way (Manojlovich & Laschinger, 2007). Laschinger and Finegan (2005) contend that a positive work environment is essential for patient safety, and that trust is a critically important leader activity. Overall, the random sample of nurses in this study felt that their environments are only somewhat empowering, with most subscales averaging below three on a five-point Likert rating. The most empowering aspects of their work are access to opportunities and positive informal alliances; and the least empowering aspects are formal power, i.e., flexibility in how work gets done. The results of this study support the proposition that staff nurse empowerment has an impact on perceptions of fair management practices, feelings of being respected, and trust, which affects work commitment and job satisfaction. However, as this study only tested one possible configuration of the work-life model and empowerment, results cannot be generalised. This limitation is recognised by the authors, who suggest that a qualitative or mixed methods approach would contribute to a more full understanding of the empowerment process.

In conclusion, many of these studies found that staff members are “*moderately empowered*”. However, these studies do not inform managers or educators about how empowerment occurs, what the process of empowerment is, or how to enhance and promote empowerment of nurses. All of the organisational studies are based on the premise that organisational structures (resources, support, opportunities and information) are the source of empowerment for the individual, without addressing the actual experience of empowerment by the employees. It is also interesting to note that organisational empowerment studies that used Kanter’s (1993) model do not appear to be culturally bound. The similarity of results across these countries may also be a cause for some concern, as there appears to be no significant difference in levels/degrees of empowerment when measured. In addition, organisational theory studies have used a quantitative approach to measure empowerment, when a qualitative approach might be more appropriate to this topic. According to Bradbury-Jones et al. (2007) in a qualitative study of nursing students, empowerment is dependent on context and is multi-factorial thus acknowledging the concept of empowerment as a complex phenomenon that may be more suited to a qualitative approach. Laschinger et al.

(2001) subsequently broadened her interpretation of empowerment incorporating psychological and organisational factors. The following section details the psychological theory studies.

2.5.2 Psychological theory studies

The seminal studies of Conger and Kanungo (1988) and Thomas and Velthouse (1990) are among the first to develop psychological empowerment theory. They base their work on that of Keiffer (1984) and Rappoport (1984), who described empowerment as a developmental process. Conger and Kanungo (1988, p. 484) argued that empowerment is a:

“process of enhancing self-efficacy among organizational members through identification [and removal] of conditions that foster powerlessness.”

Thomas and Velthouse (1990) subsequently further developed a model of empowerment, describing three stages of human existence necessary for empowerment: belief systems, assessment and enactment processes. Spreitzer (1995; 1997) tested the models of empowerment developed by Conger and Kannungo (1988) and Thomas and Velthouse (1988).

Spreitzer (1995) developed the psychological empowerment (PE) theory that recognises a set of dimensions required in order for an individual to feel empowered. The following dimensions are necessary for empowerment to take place: competence, impact, meaning and self-determination. Competence refers to feelings of self-efficacy, or one's own ability to complete a task; impact refers to the degree to which the task will have meaning, or the individual's ability to influence organisational outcomes; meaning refers to the relevance an individual places on an individual task based on the her/his own personal standards; and self-determination/choice refers to feelings of autonomy in making decisions about work. Spreitzer (1995) noted that if any one of these dimensions is missing, then the individual will experience limited empowerment. Spreitzer (1995) devised a measurement scale known as the psychological empowerment questionnaire (PEQ) to measure each of these constructs and the totality of empowerment of an

individual. A critique of Spreitzer and Donneson (2005) approach, is that that this theory is individual centric. It therefore does not facilitate the inclusion of the clinical environment or recognise the importance of other factors such as culture in the empowerment process of nurses. The PEQ has been used extensively internationally, and has been translated into many languages. Ibrahim (2010) in Egypt; Laschinger et al.(2004) in Canada Li *et al.* (2008) in Taiwan; Uner and Turan (2010) in Turkey and Leggat et al. (2010) in Australia. This range and variety of studies demonstrates that empowerment is relevant and applicable to an international audience and that the PEQ is not culturally bound. However it provided a “measure” of empowerment, rather than illuminating the actual process. Therefore, across the many continents, the level of empowerment among nurses has been computed, while the knowledge of what is empowering or disempowering them, or how to improve or transmit empowerment, is lost to the organisation.

Kuokkanen, et al. (2002) developed an instrument based on five categories obtained from a previous qualitative study (Kuokkanen & Leino-Kilpi, 2001). Two pilot studies were conducted to test the reliability and validity of a questionnaire. The qualities of empowered nurse scale (QEN-S) measured 19 items using a five-point Likert scale (1= wholly disagree to 5= wholly agree) and the performance of an empowered nurse scale (PEN-S) also measured 19 items using a similar Likert scale. These questionnaires were distributed to a randomly-selected sample of 416 registered nurses, and achieved a 69% response rate. Nurses described moral principles as their best quality while future-orientation was their least reported quality. When asked “*do you consider yourself an empowered nurse?*” 51% answered “yes”, 33% were undecided (which may reflect the transient process of empowerment), while 15% answered “no”. A limitation acknowledged by the authors was that that some of the questions were slightly ambiguous. This work by Kuokkanen et al. (2002) is one of the few studies that did not use Spreitzer’s (1995) PEQ to measure psychological empowerment, and serves to emphasise the importance of the individual perspective of the nurse on empowerment, and the transient nature of empowerment within the individual’s perspective. It is the only study focusing solely on the qualities of the empowered

nurse – an important consideration which highlights the complexities of factors contributing to this phenomenon.

Sparks (2011) found, in an American comparative study of two generations of nurses (n=451), that older nurses were more empowered than younger ones. This study measured the psychological empowerment of nurses, using Spreitzer's PEQ (1995). The author suggests that this is not so much about age as about the ability to find meaning in the work environment. If psychological empowerment can be improved for younger nurses through targeting ways of finding meaning in their work, there will be a resultant rise in job satisfaction. However Casey et al. (2010) suggested that without empowerment, employees find little meaning in their work. Earlier literature (Thomas & Velthouse, 1990) noted the difference in age, and as a consequence the value placed on jobs. Another possible explanation for older generation nurses' increased feeling of job satisfaction is that they may not have the demands that younger nurses may have with families. Consequently, older nurses may find their work more rewarding and fulfilling. Details of work-life balance issues such as home life, children, and distance from work, are not included in data; and this is acknowledged by the author as a limitation.

To summarise, psychological theory of empowerment supports the influence of the individuals' response to their environment in relation to meaning, self-determination, impact and competence. From Kuokkanen et al. (2002) this is a personal attribute or quality. This would suggest that the environment, while important, interplays with the individual creating the empowered nurse. However, the quantitative measuring of empowerment in Spreitzer's (1995) PEQ and Kuokkanen et al. (2002) does not explain how nurses are empowered and if it is enduring. The following section discusses the critical social theories' perspective on empowerment theory.

2.5.3 Critical social theory studies

Critical social theory is based on the premise that certain groups in society maintain subordinate positions. Critical social theory originated in the Frankfurt School, Germany, in the 1920s (Kuokkanen & Leino-Kilpi, 2000). The use of

critical social theory for research is based on the premise that individuals have the capacity to reflect on themselves and to act independently. Oppression is always a factor with critical social theory, and this has relevance to nursing as it is frequently referred to as a “*oppressed group behaviours*” profession (Daiski, 2004).

Freire (2000) developed his theory of oppression after studying in South America. He suggested that the oppressed are fearful of change in power structures, as the oppressed grow dependent on their oppressors. Others, such as Roberts (1983), believed that Freire’s theory has a particular relevance to nursing. Nurses are commonly perceived as being “weaker” or subservient (Lewis & Urmston, 2000), and are viewed as acquiescing to the more powerful and adopting a lesser role in the provision of care in relation to the medical doctor (Porter, 1991). Witz (1992) and Davies (1995) found that the healthcare environment is hierarchical and oppressive.

Studies using critical social theory Pearson (1998), noted that students have a perceived increase in power in conjunction with increased responsibility. Falk-Rafael et al. (2004) used feminist theory in their exploration of empowerment within an academic, rather than a clinical, context. Fulton (1997) employed critical social theory in the first British study to explore empowerment and nurses, and equated empowerment with liberation. This small-scale study used only two focus groups, the participants of which were already enrolled in Fulton’s empowerment for practice course at Southampton University’s School of Nursing and Midwifery.

Three main themes emerged from this study:

1. Feeling right about oneself
2. Having personal power
3. Relationships with multi-disciplinary team

Despite the limitations of this small-scale study (Fulton, 1997) of 16 participants from a self- selected sample, many of the themes were mirrored in a large national study performed in Ireland among nurses and midwives (DoH & C/DCU, 2003).

This was a two phase study: phase 1 was a focus group discussion and phase 2 was a survey (response rate 46%). The factors found to enhance feelings of empowerment were: nurse education, clinical skills, knowledge and self-confidence, while impeding factors identified were: poor management style, lack of education, lack of support, and lack of recognition. Concurring with Corbally et al. (2007), this study of 93 nurse practitioners in Ireland (n=93) found that education for practice acted as an antecedent to empowerment. This is further evidence of the multifaceted and complex way in which empowerment may be fostered and foiled in health care. A limitation of this study, acknowledged by the authors, was that the sample was selected by the Directors of Nursing.

From a critical social theorist's perspective, oppressed nurses are viewed as striving for liberation from oppression which is imposed through historical legacy and culture. Lack of recognition and lack of power, as discussed in section 1.10.5, are also contributing factors to empowerment or disempowerment of staff. When empowerment is viewed using critical social theory, many aspects of healthcare culture and socialisation of nurses are acknowledged that are excluded from organisational and psychological theory.

To summarise, critical social theory's approaches explore empowerment from the perspective of nurses being in an oppressed or subordinated position. Evidence in the literature of stressful and hierarchical environments would support this. The clinical environment in which nurses and nursing students practice has been described as hierarchical and submissive (Daiki, 2004); stressful (Coomber and Barriball, 2007); and open to domination and oppression (Witz, 1992; Davies, 1995). It is therefore necessary to address if or how a culture of empowerment exists in health care, acknowledging the positive impact it may have on staff by buffering them against the harshness of their working environment. The following section discusses the mixed theoretical approaches on empowerment studies.

2.5.4 Mixed theoretical approaches

Laschinger et al. (2001), and Manojlovich and Laschinger, (2002) identified a connection between psychological empowerment (PE) and

structural/organisational empowerment (SE). PE was found to be an outcome of SE, while both were found to be related to job satisfaction. Casey et al. (2010), in an Irish study, used critical social theory as a framework to test if SE and critical social theory (CST) were positively related to PE. The authors posit that access to organisational empowerment, critical social theory empowerment, and psychological empowerment had a positive impact on job satisfaction. A convenience sample of qualified nurses attending a three-day leadership course were surveyed (n=306), though potential bias was not acknowledged by the authors. Virtually all respondents perceived they were doing meaningful work competently, with 97% reporting that competence and meaning are core values of work. In the study, 44% reported that they believed they had little impact within their departments. This is one of the few examples of a study that incorporated the critical social empowerment with the psychological and organisational perspectives. It is clear that, when empowerment is viewed as a mixed approach rather than using purely organisational or psychological theory it broadens our understanding of empowerment.

Improving patient care is an unarguable focus of all health care policy and practice. Empowered staff it would appear can or should impact patient care. However, few studies have addressed the question of how an empowered nurse can enhance patient care. Ward environment and ward culture are important contributors to patient care and safety (Kirwan et al., 2013). A large-scale international study involving hospitals from the America and Europe confirmed the impact that the hospital work environment has on the quality of care delivered (Aiken et al., 2012). Aiken et al. (2012) study acknowledges the importance of the environment to staff and the impact of the environment on staff well-being. Laschinger et al. (2010a) suggested it is imperative that the nurse use empowerment to empower the patient/client for better functioning and health. However, despite the importance of empowerment to nursing, there are few models that have integrated the empowerment of nurses with that of patients. Laschinger et al. (2010a) provided a theoretical model that incorporates workplace empowerment and patient empowerment in a single framework. This model builds on the previous one used by Laschinger et al. (2001), and combines the work of Kanter (1977; 1993) and Spreitzer (1995). Patient empowerment is

conceptualised as the patient's access to information, support, resources and opportunities.

Kanter's theory describes two main empowerment structures in organisations (1979 & 1993):

- Structural opportunity (job conditions, ability to develop their skills)
- Structure of power (lines of information, lines of support, lines of resources)

Access to these empowerment structures is facilitated through formal and informal power systems. According to Kanter (1993), when individuals do not have access to these structures they experience powerlessness. Spreitzer (1995) as described in section (2.5.2) on psychological theory studies developed a theory relating to psychological empowerment (PE) that recognises a set of dimensions required in order for an individual to feel empowered: competence, impact, meaning and self-determination. To date this model has not been tested empirically however; it does present an opportunity to further develop the understanding of empowerment and the benefits of its application. Laschinger et al. (2010a), through their inclusion of PE, acknowledged the importance of the psychological component of empowerment combined with organisational factors for nursing empowerment. However the process of empowerment remains unexplored within this model as it serves to reduce empowerment to a number of conditions. It is clear however that the addition of the psychological component to empowerment has furthered the understanding of empowerment and it presents opportunities for further developing it within the clinical practice area.

In conclusion, mixed theoretical approach studies provide an opportunity to view empowerment from a psychological or individual perspective, as well as from an organisational perspective. This provides a broader lens to explore empowerment and has the potential to further deepen one's understanding of this complex phenomenon. Results from these studies demonstrate the patient benefits and organisational benefits of an empowered workforce. These studies go some way

towards addressing how we can empower nurses, by viewing empowerment as a multifaceted concept rather than purely an organisational or psychological concept. Many of these studies, however, fail to include historical legacy, power and culture as contributing factors to, or components of, empowerment (Pearson, 1998). Nurses are studied in isolation from how the organisation developed, and many of the research studies concentrate on quantifying empowerment rather than exploring the process and reality of empowerment with nurses.

2.5.5 Studies specific to nursing students and empowerment

There is a dearth of studies that have focused on empowerment of nursing students, and many of those published are concerned with empowerment in academia. Pearson (1998) used a grounded theory approach to research empowerment from a teaching perspective with six second-year nursing students in New Zealand. The focus of this study was on the academic and faculty teaching/curriculum and therefore it did not explore if or how the clinical placement affected the nursing empowerment levels of the students. A recommendation of this study is that preceptors in education should include historic, socio, cultural and political awareness (Pearson, 1998).

Bradbury-Jones et al. (2007), in a study of empowerment among undergraduate nursing students, used critical incident technique to elicit the meaning of empowerment for nursing students in clinical practice. The findings of this study of 66 nursing students showed that they experienced empowerment and disempowerment in three main areas while on placement: learning practice, team membership, and power. The support of the preceptor was pivotal to the empowerment of these students (Bradbury-Jones et al., 2007). However, critical incident technique as a methodology is later criticised by Bradbury-Jones and Tranter (2008, p. 399) who state that:

“A great deal of inconsistencies have been created by nurse researchers trying to advance the cause of Critical Incident Technique. This has led to confusion which is not helpful to advancing nursing knowledge”.

More recently, Bradbury-Jones et al. (2010), in a longitudinal study of 13 first-year undergraduate nursing students in the United Kingdom, adopted a phenomenological approach to uncover the students' real-life experience and their understanding of the concept of empowerment. Bradbury-Jones et al. (2010) study showed the trajectory of empowerment/disempowerment over a period of three years. In this study (Bradbury-Jones et al. 2010) confidence and knowledge are identified as factors impacting empowerment. As this study used a phenomenological approach, emphasis was on the nursing students' real-life experiences, therefore other contributing factors to empowerment/disempowerment were not taken into consideration. However, in order for us to fully understand empowerment, we need to contextualise the undergraduate nursing students' experiences against the culture and the organisational factors that affect empowerment because of the complex nature of the phenomenon.

Levett-Jones and Lathlean (2008) interviewed 18 participants in an Australian study on their understanding of belongingness while on clinical placement. Interestingly, a finding of this study is that when students felt part of a team they reported feeling more empowered. Learning, confidence and empowerment occurred when the students felt part of the team in this study. Anxiety and stress were perceived as barriers to learning.

A contemporary study into the empowerment of nursing students in Korea (Aha & Choi, 2015) asked a sample of 370 nursing students to complete a survey. This study used the Spreitzer's (1995) Psychological Empowerment Scale (PES), Rosenberg's self-esteem scale (1965), and a clinical decision-making tool developed by Jenkins (1985). This study used previous studies by Bradbury-Jones to explore with the Korean students the concepts of empowerment. Confidence was an element suggested by Bradbury-Jones et al. (2010) as being a precursor to empowerment. Aha & Choi (2015) in their study used in Spreitzer's (1995) PES. In doing this they used competence was a measure of confidence. This is a limitation of the study as competence and confidence are connected, but are different concepts, and should not be confused. The findings of this study support the importance of empowerment to educational outcomes and the

influence of being valued, preceptors' relationship with student, clinical decision-making and self-esteem as contributing towards empowerment.

There appears to be a paucity of studies investigating empowerment of nursing students despite its importance to nursing and nursing care (Bradbury-Jones et al., 2011). Bradbury-Jones' study of nursing students' empowerment has made an important contribution to this topic. However, the use of phenomenology and critical incident technique to investigate empowerment means that factors outside the student experience may not be acknowledged as influential. Therefore, the Bradbury-Jones et al. (2010) study demonstrates the necessity for further studies on empowerment to provide context and understanding to the empowerment of nursing students. Aha & Choi (2015) suggest that there is a need to investigate the sociological and political factors influencing empowerment that are described by Bradbury-Jones et al. (2010) as 'extrinsic spheres of influence'. In addition the process of empowerment for nursing students remains unclear and the influence of clinical practice on the nursing students practice. More specifically, there appears to be a lack of evidence relating to how or indeed if nursing students are empowered in clinical practice. This study on empowerment aims to further the existing body of knowledge on empowerment of nursing students in clinical practice and bridge the gap that exists in the published literature.

2.5.6 Chapter summary

This literature review chapter has identified many studies using organisational, psychological, critical social theory and mixed theory approaches. The organisational theory studies included demonstrate how access to information, support and resources support the empowerment of nurses without inclusion of the individual factors. The psychological theory studies, on the other hand, highlight how an individual nurse can bring his/her competencies to the workplace which, in turn, affect empowerment such as impact, meaning, competence and self-determination. Many studies included from diverse international perspectives found that nurses are empowered within these competencies. Mixed theory studies demonstrate the evolution of empowerment theory as it encompasses more of the critical factors that are seen to affect empowerment. The impact of

psychological theory studies can be seen in their inclusion laterally in some of Laschinger's studies (Laschinger et al., 2010a). The critical social theory studies used a critical lens to view empowerment and the factors that have an impact on the empowerment of nurses. These critical social theory studies are nevertheless cognisant of hierarchical and oppressive cultures that existed in nursing, a factor which is not captured in organisational and psychological theory studies.

This illustrates the evolution of empowerment theory in the inclusion of the individual, and recognising the environment and organisational supports, thus providing a more authentic framework of empowerment.

The studies that focused on undergraduate nursing students found that nursing students were both empowered and disempowered in clinical practice. The use of phenomenology and critical incident technique by Bradbury-Jones et al. (2007; 2011), to explore empowerment with nursing students, fails to capture the entire empowerment process. Rather it relies on the nursing student's description of their personal experience to capture what it is to be empowered. The present study aims to address this gap in the literature through the use of Social Domain and Adaptive Theory. It is proposed that nursing students' experiences and perceptions of empowerment will be further illuminated by adopting this approach. In addition taking cognisance of both the sociological and cultural components of nursing it will help deepen and develop further understanding of empowerment/disempowerment. It is timely that this void in the literature is addressed, in recognition of the potential contribution empowered staff and nursing students can make in the clinical learning environment.

The subsequent chapter presents the research methodology.

Chapter 3: Methodology

3.0 Introduction

The previous chapter provided a critical appraisal of the literature on empowerment and empowerment theory. This chapter presents the underpinning philosophical and theoretical perspectives used in the present study. Section 3.1 provides an introduction to the philosophy and theoretical underpinnings for this study. Following a review of the research aim and research questions (section 3.2), the research philosophy for the study is presented. An explanation and defence of the ontological and epistemological premise (section 3.3) on which this study is based is followed by a description of Social Domain Theory (section 3.4) and Adaptive Theory (section 3.5), describing their suitability for this study and how they have been applied (2005; 2006). Power is acknowledged in Social Domain Theory and is also presented here as a factor that requires consideration within the methodology. Section 3.6 presents the research process, ethical considerations (section 3.7) providing detail on the study design (section 3.8), the sample, research setting, methods of collection (section 3.9), and the data collection process employed to address the research questions. The final section describes data analysis (section 3.10) using Layder's Adaptive Theory (2006). An example of data analysis and a mind map used to conceptualise the analysis is provided in the appendices (Appendix 6 and 7). A description of the characteristics of each of the focus groups is provided followed by a short description of the utility of NVivo in the study (section 3.11). The changes that occurred (section 3.12) throughout the study are presented followed by a reflective section titled 'researchers voice' (section 3.13) in keeping with Social Domain Theory (Layder, 2005). The chapter concludes with a chapter summary (section 3.14).

3.1 Introduction to the research philosophy and theoretical position used in the study

At all stages throughout this study, the complexity of the participants' experience of empowerment in the social world have been presented to the reader acknowledging the multifaceted, complex nature of nursing (participants' social reality) in the clinical learning environment. This was accomplished through the use of Layder's (2005; 2006) Social Domain Theory and Adaptive Theory (see section 3.4). By using these theories (section 3.5), and their inclusion of a stratified approach to looking at the social world, facilitated a deeper analysis of empowerment as experienced by the participants. Layder's Social Domain Theory provided the philosophical approach for this study, while Layder's Adaptive Theory (2005) provided a methodology that can be used in conjunction with Social Domain Theory. Adaptive Theory is concerned with adapting the analysis and interpretation of data (Layder, 2005) through the provision of practical research strategies related to the development of social theory. Following an extensive review of the literature as presented in the previous chapter, the following questions were posed, in order to more fully explore the concept of empowerment of nursing students:

3.2 Research questions

1. What do nursing students understand by empowerment?
2. What are the factors that impact empowerment development during final clinical placement in undergraduate nursing students?

The following section presents the theoretical deliberations on the use of Layder's Social Domain Theory (2006), and provides a rationale for why Social Domain Theory was selected as an appropriate methodology for this study. It is followed by a description of how Adaptive Theory was applied to the present study.

3.3 Theoretical deliberations

This section presents a justification for the use of Layder's (2006) Social Domain Theory as a social ontology, and Layder's Adaptive Theory (2005) as a methodological approach for the study of undergraduate nursing students in clinical practice in relation to their experience of empowerment during clinical placements

3.3.1 Research philosophy

A research philosophy can help to identify the type of evidence required, how to gather it and how to interpret it in order to find an answer to the basic problem under investigation (Robson 2011). The methodology selected in research studies is influenced by the philosophical paradigm that best reflects my understanding and perspective of our social world. Paradigms are often characterised in terms of the ways in which an individual may respond to fundamental questions on his/her philosophy of social reality (Polit & Hungler, 1997). There is no universally accepted paradigm for research, but consideration of what exists together with one's own philosophical approach is helpful). As noted by Babchuk & Badiie (2010, p. 27):

"Although potentially daunting to those unfamiliar with this material, gaining an understanding of these philosophical orientations provides a foundation for researchers to position themselves when conceptualizing their own research designs, a rationale for choosing qualitative methods (as opposed to quantitative) to answer a research question or questions, and why a specific approach (e.g., phenomenology, case study, etc.) and type of approach (e.g., constructivist vs. objectivist grounded theory) was selected over other options".

3.3.2 Ontology

Ontology refers to the type of things that exist in our social world, and assumptions about our social reality (Gomm, 2008). Three distinct ways of understanding reality (ontological positions) are: idealism, realism and materialism. Giddens (1984) and Bhaskar (1979) argued that a philosophy of reality must begin with a

theory of “being” (ontology), as distinct from a theory of “knowing” (epistemology). Layder (2005), however, believed that the nature of reality (epistemology) and how we know about it (ontology) are inextricably linked and cannot be divorced from one another.

A positivist ontological perspective supports the view that there is a reality attached to our social world, and the epistemological stance would be to objectively capture that reality in research. Positivists will suspend or withhold their individual perspectives while investigating the phenomenon of interest (Polit & Hungler, 1997). Within the naturalistic (constructivist /interpretivist) paradigm, writers such as Weber, Kant and Bhaskar began a counter movement to the positivists (Layder, 2005). For the naturalist researcher, reality exists within a context and naturalists therefore acknowledge the multiple interpretations of reality (Polit & Hungler, 1997).

A positivist approach to exploring empowerment therefore, in the context of this study would mean suspending or not acknowledging experience gleaned from working with nursing students. For this study, it is important to acknowledge the social standpoint, throughout the various stages of the research process. From a naturalistic epistemological perspective, there are no issues of objectivity and distance between the researcher and the participant: in fact, the opposite is true. The findings of a naturalistic enquiry are a by-product of the interpretation of the researcher and the participant. For example, in relation to the undergraduate nursing students’ social reality in this study, it is important not only to capture what nursing students describe, but also to record their prior knowledge and experience of the social setting and context. Layder (2005) advocates the suitability of Social Domain Theory and Adaptive Theory as being particularly relevant where the interweaving of social systems and people are being explored. This therefore demonstrates the suitability of both these theories in this study and how it is beneficial to use prior knowledge and experience in order to look for meaning in the participants’ responses, thereby adding to the depth of knowledge and understanding on empowerment of undergraduate nursing students.

The positive, quantitative research tradition is more closely aligned (although not exclusively) to positivism, whereas qualitative research is associated with naturalistic inquiry (Polit & Hungler, 1997). Researchers who favour the naturalistic tradition are frequently critical of the reductionist tendency of the positivists. This would suggest that a limitation for some topics of research is that only an element (rather than an entire phenomenon) can be considered.

Following a review of the literature, it was apparent that many researchers attempted to quantify the degree of empowerment experienced by qualified nurses, and therefore employed a quantitative approach (Spreitzer, 1995; Laschinger et al., 2001; Sparks, 2011). The results of these studies do not provide the richness of data that is anticipated in exploring empowerment in the present study. For example it is important when exploring a topic such as empowerment that is complex and ambiguous to unravel what the participants' knowledge and understanding of what it means to be empowered. In the present study participants discussed and explored the topic in a focus group. This level of discussion is difficult to achieve through the use of a questionnaire and so quantitative studies fail to achieve this deeper level of understanding of empowerment. Corbally et al. (2007, p.170) suggested that a criticism of quantitative approaches is that many of the quantitative studies reported participants being "*moderately empowered*". It is clear, therefore, that a quantitative methodology would be incapable of informing or addressing the dearth of knowledge that exists in the published literature, and could not answer the research questions formulated for this study. Such a methodology would not provide the data that would demonstrate if or how undergraduate nursing students are empowered while on clinical practice.

3.3.3 Interpretive tradition

Within the naturalistic tradition, many options were considered, such as phenomenology, ethnography, case study and grounded theory. According to Polit and Hungler (1997, p 14):

“Naturalistic studies result in rich, in-depth information that has the potential to elucidate the multiple dimensions of a complicated phenomenon”

Fulton (1997), who was the first to study empowerment in a British study amongst undergraduate nursing students, stated that grounded theory is not suitable as a methodology as it naturalises the present without taking the history into account. Bradbury-Jones et al. (2010) was the first contemporary study to use phenomenology to describe the nursing students' lived experiences of empowerment, and by doing so made an important contribution to the literature as it used the voices of the nursing students to describe what empowerment was. However, as phenomenology explores the nursing students' experiences without the acknowledgement of other contributing influences such as culture, power and historical legacy, Aha & Choi, (2015) suggested that these concepts require further exploration. The multiple realities that exist in the complex world of clinical practice need to be acknowledged in the methodology in conjunction with the voice of the nursing students as they add meaning. Social Domain Theory facilitates the acknowledgement of prior theory while exploring the current context, including the historical and sociological context. It is imperative that the nursing students' social world and reality is incorporated into the research methodology and not suspended or ignored. Therefore, within this study, Social Domain Theory builds on the work of Bradbury-Jones to further understanding of nursing students' experience of empowerment.

3.3.4 Realism

Realism provides a way to approach real-life scenarios in the complex social world that we live in (Robson, 2011), and realists see knowledge as a social and historical product. This is important in relation to exploring empowerment with a cohort of undergraduate nursing students. In the final report on a large Irish study on empowerment, the conclusion was that:

“There is a complexity of issues that surround a nurse's or midwife's understanding and experiences of empowerment” (DoH & C/DCU, 2003, p.15).

Layder's methodological approach is underpinned by a realist meta-theory and focuses on the merging of the macro (organisational, institutional) and the micro (individual) features of daily life (Bergin, 2011). Therefore, in this study the views of undergraduate nursing students are a combined synthesis of their education, individual personality, life experience and placements – i.e., this is their social reality that this study strives to understand and convey.

3.3.5 Epistemology

Epistemology is concerned with the nature of knowledge and ways of knowing and learning about social reality. Two main perspectives for knowing are positivism and interpretivism (constructivism and naturalistic methods). Polit and Hungler (1997, p.10) described epistemology as

“the relationship between the inquirer and that being studied”.

A criticism of positivists is that they fail to recognise that human behaviour is frequently unpredictable (Layder, 2005). Proctor and Capaldi (2006) are also critical of the logical positivists' stance, rejecting the view that science should only deal with observable phenomena. Alternatively, a criticism of an interpretive approach is that it reduces the social world to an interpretation of inter-subjective communications, and neglects to include the influence of larger social structures, such as culture, systems, structures and ideology (Layder, 2005).

In relation to exploring the concept of empowerment, it is important to capture both the objective and subjective elements of the phenomenon. In this respect, it is my view that reality is composed of many differing and opposing views which are complex and difficult to define. There is no one single reality for many of us rather, there are multiple realities. Layder's approach acknowledges the reality of the social world while avoiding the reductive tendencies of symbolic interactionism, phenomenology and grounded theory (Layder, 2006). It therefore seems appropriate to use subjective and objective data in this study of undergraduate nursing students' perceptions of empowerment, applying Layder's Social Domain Theory (2006) and Adaptive Theory (1998; 2005) to capture their reality.

3.4 Social Domain Theory

Layder's (2006) Social Domain Theory offers the possibility of understanding social reality – in this case the empowerment of undergraduate nursing students in clinical practice, in conjunction with the complexities that exist in clinical practice/social reality. Layder (2006) argued that other approaches (for example those of Foucault and Giddens) present a single/dual reality of our social world. The complexity of the undergraduate nursing students' social world can be explored through the use of Layder's social domain and Adaptive Theory. Social Domain Theory rejects the notion of dualism, as offered by Foucault and other postmodernists, and advocates adopting a multi-dimensional view of the social universe. Layder (2006) views the social world as having four interconnected domains:

- Domain of Contextual Resources
- Domain of Social Settings
- Domain of Situated Activity
- Domain of Psychobiography.

Social Domain Theory differs from interactionism and phenomenology in that it asserts that the creation of meaning is not limited to one domain (situated activity), but rather is an amalgam of the influences of different domains. As discussed in section 2.4., power is an important aspect of empowerment. Within Social Domain Theory, Layder incorporated power within each of the domains. Layder (2006) argued that such a perspective acknowledges the richness, complexity and depth of the social universe. These qualities, he asserts, are denied or obscured by the reductive tendencies of other theories.

3.4.1 Domains as applied to the study

It is important to acknowledge the complexities of the social world and reality of the participants in this study, i.e. the undergraduate nursing students. On exploring empowerment of undergraduate nursing students, it is evident that the

context (placement) and cultural/organisational influences are important factors to consider. The nursing students in the present study were in their fourth and final year of a nine-month clinical internship, and were immersed in clinical practice at the time of the study. The clinical learning environment and practice constituted the participants' social world and represents their reality. Within this section each of Layder's domains (2006) are described as they apply to the nursing students in this study specifically. This section also includes a short paragraph on power and its relationship to each of the domains. The subsequent section (3.5) provides a rationalisation for the use of Adaptive Theory in this study.

Domain of psychobiography (subjective domain)

The psychobiography domain is where the individual's personal experiences fit. These unique experiences have shaped an individual and are recognised for their importance in contributing to that person within this domain. It is therefore possible through this domain to track and trace the person's individual and important life events. The domain of psychobiography recognises the uniqueness of people's experiences in tandem with their unique response to their social relationships. Within the context of the study, each nursing student's unique perspective on the process of empowerment/disempowerment within the clinical experience may differ significantly, despite the fact that the students experience similarities in the clinical area, and are governed by the same organisation. As observed by Layder (2006, p. 275):

"Because we are unique, the fit between the individual and society is imprecise, imperfect and much more tenuous than most sociologists would allow.... Indeed from the point of view of domain theory, anxiety and insecurity are never completely allayed, conquered or successfully 'inoculated' against".

Layder (2006, p. 274) explained that individuals exist both "*inside*" and "*outside*" society. This means that while each individual cannot escape from society, the individual influence of the person (undergraduate nursing student) is relevant and significant in all experiences (Layder, 2006).

Domain of situated activity (subjective domain)

Situated activity, according to Layder (2006), is the domain where meaning is recognised. This corresponds with the belief of phenomenologists and ethno methodologists, that the creation of meaning occurs where there is social interaction. Blumer (1969) and Garfinkel (1967) emphasised that meaning is linked uniquely to the situation where it arises. However, Social Domain Theory departs from those listed above, as it does not subscribe to the theory of the creation of “meaning” being solely in the context of the interaction. An example of this, within the context of the study, might involve a participant conversing with a preceptor. The meaning and outcome of the conversation does not depend solely on the outward encounter, but rather on the context and subtext that exists. Layder’s view (2006) is that meaning is created across the domains, and is partly a by-product of the domain of psychobiography and partially the consequence of social interaction. For example, in the present study, each individual nursing student’s formative experiences of learning will have been different and therefore each student will have a unique past as well as a shared present (clinical placement). Hence, the individual interaction within the clinical placement will predicate and influence future relationships with preceptors, and may also be a factor in the undergraduate nursing students’ experience of empowerment/disempowerment while on clinical placement. Therefore, Layder’s Social Domain Theory, while acknowledging the social interaction in the same way as phenomenologist’ and others, also provides another lens from which to view that interaction, and ultimately offers a richer and more meaningful understanding.

Domain of contextual resources (objective domain)

The domain of social settings and the domain contextual resources form part of the objective realm of society (Layder, 2006). The objective realm of society is concerned with the structures and social contexts as opposed to the subjective, where what people think and do is the primary concern. The domain of contextual resources is an important domain, as it facilitates the inclusion of the structural aspects of social life, such as schools, hospitals, churches, universities and commercial firms. Not all of organisations need to be formal: some are small and

informal, such as families and friendship networks and nursing student groups. Whether formal or informal, all social settings are based on reproduced social relations and practices, and as such influence our behaviour in the present (Layder, 2006). Within the context of the present study, it is important, as stated in section 1.7.5 and section 2.4, that the hierarchical influences in nursing are significant today and require acknowledgement.

Contextual resources are referred to by Layder (2006) as representing the social environment in two elements. Firstly, they comprise material resources which are allocated in accordance with class, ethnicity, race, gender etc. This ultimately shapes communities and families in social settings in the provision of schools, health centres and social welfare. The second element of contextual resources is the historical accumulation of cultural resources such as knowledge, *mores*, media, style and popular culture, which shape culture and the way we think. These would correspond to Parsons' (1951) cultural system. This domain is the macro domain that is concerned with power, resources, material inequality, and cultural values and beliefs (Sibeon, 2004). This domain has relevance, as previous studies (Klusa et al., 2004; Laschinger et al., 2011) have demonstrated the correlation between empowerment levels of registered staff in relation to organisational and resource related theory.

Domain of social activity (objective domain)

The domain of social activity in the context of this study provides a tool that facilitates the inclusion of the culture of the ward, organisation and profession in the context of the interaction or experience, as described by the undergraduate nursing students. This is crucial to the understanding of empowerment. Layder (2006, p. 279) described situated activity as:

“A subtle and complex amalgam of the powers, emotions and mutual influences of multiple individuals that unfolds in the real time of the encounter”

Recognition is given, in this domain, to the context (placement in the present study), thereby addressing the research question of the empowerment process for

the undergraduate nursing students. For example, how do the participants in this study feel within the ward? Are they included? Are they empowered? Are they accepted and approved of? Are they disempowered? If they feel that they are valued and approved of, this is an important factor to capture in relation to the theory of empowerment, as described by (Spreitzer, 1995; Kuokkanen et al., 2002). Layder (2006, p. 279) referred to this as the “underground” emotional work which is essential to capture.

Power and social domains

Power is embodied in all four domains in different ways. As described in section 2.4, it is not possible to explore empowerment without acknowledging the influence of power. Equally, within our understanding of our social world, power infiltrates all relationships and experiences. This is acknowledged by Layder (2006), through his embodiment of power in all four domains. This too has particular resonance for the present study, as power penetrated all themes and in fact was acknowledged at the outset of the research process and in section 4.5.

3.4.2 Summary of Social Domain Theory

Social Domain Theory presents a theory that is capable of capturing the multi-dimensional perspective of a given situation or research topic. It does this through its acknowledgement of multiple realities in the representation of our social world in terms of the four domains. The complexity of the participants’ social reality in all its facets is captured through the use of Social Domain Theory through acknowledging the importance of social space, power, culture context and meaning as described above. The following section details Adaptive Theory and how it facilitates Layders’ (2006) view of the social world (Social Domain Theory) as a methodology for the present study.

3.5 Adaptive Theory

Adaptive Theory is a “middle-range” theory in terms of immediate focus, but has an “open-ended” relationship, with larger-scale or more inclusive theories, or types

of research (Layder 1998; 2005). Adaptive Theory is so called according to Layder (1998; 2005) as it is a flexible theory that utilises present and existing data and is capable of being flexible and responsive in data analysis and interpretation. Adaptive Theory combines the use of pre-existing theory and theory generated from the research process in the formulation and actual conduct of empirical research. This makes Adaptive Theory suitable for the present study, as previous studies such as Bradbury-Jones et al. (2011) contribution can be acknowledged and advanced in order to further understanding and appreciation of empowerment. Other approaches such as phenomenology and grounded theory do not offer the same flexibility and opportunity to develop new theory or new knowledge as they are limited in terms of their understanding of the social world and their appreciation of existing theory. Adaptive Theory is therefore a methodology that facilitates a continuous relationship within the research process between previous theory and emergent theory and any new theory that emerges. Adaptive Theory both shapes, and is shaped by, the empirical data that emerges from research. It allows the dual influence of extant theory (theoretical models), as well as those that unfold from (and are enfolded in) the research. Adaptive theorizing is an ever-present feature of the research process

3.5.1 General characteristics of Adaptive Theory approach

This section describes the characteristics of Adaptive Theory approach and Layder's (2005) rules that guide the application of Adaptive Theory to this study. This section concludes by summarising the application and suitability of Adaptive Theory to the study of empowerment of nursing students while on clinical practice.

The pace of theory development during the research study is unique to the study underway. The ability to interpret and analyse data is just as important as the data appropriateness and relevance. Layder (2005) acknowledged the unpredictability of theory generation and views every phase of the research study as an opportunity for theory generation. This differs considerably from other approaches, where there is a particular phase where theory generation is supposed to occur. This is not the case with "adaptive" theory, which facilitates an accommodative reflexive approach to theory generation.

There are diverse forms of Adaptive Theory in order to represent the many and complex social realities and lifeworld systems. Layder (2005) advocated that all researchers should work on the assumption that a variegated social world is a reality rather than aspiring to the principle of uniformity. In addition Layder (2005, p. 175) states:

“Newly generated concepts, which ‘stand apart’ from the pack so to speak, may turn out as significant as others that are currently regarded as core or central.”

Adaptive Theory also represents any element of the analytical process that contributes to the generation of theory. This means that the development of codes, memos and categories are all integral parts of the process of Adaptive Theory.

Due to the constantly evolving and cyclical nature of Adaptive Theory the end product of Adaptive Theory is viewed as the “interim product”, depicting the constant evolution and change that represents our social world. Adaptive Theory uses *both* inductive and deductive procedures for developing theory (Layder, 2005). This is not dissimilar to other traditions. For example, Strauss (1987), from a grounded theory tradition, states that both induction and deduction are employed. However, it is also clear from a grounded theory perspective that Glaser and Strauss (1967) only allow for this within an overall inductive procedure (Layder, 2005). Therefore, deductive methods are only employed within certain circumstances. Within the Adaptive Theory approach, a more “open” approach is adopted than with inductive and deductive methods. This means that inductive and deductive methods can impose their dual influence on theory construction, but also exert a dual influence on each other. Within Adaptive Theory, both have equal importance from an epistemological perspective (Layder, 2005). Therefore, Layder (2005) does not view induction/deduction as a unidirectional flow within Adaptive Theory, but rather acknowledges the complexities and challenges of real life research. An example of this within this study is the inclusion of the students’ experiences of empowerment together with anecdotal knowledge and experience as a nurse and educator in the interpretation of data and its’ analysis. This is in

conjunction with the use of relevant literature consulted throughout the data analysis phase of the study (Chapter 4). This inclusion of experience and existing literature *brings* depth and understanding to the study of how or if nursing students are empowered when in clinical placement.

3.5.2 The range and scope of Adaptive Theory

Adaptive Theory assumes the position of being a “middle range” theory:

“It is this set of agency-system linkages that provides the ‘hook’ of the research focus and problem orientation” (Layder, 2005, p. 148).

Adaptive Theory provides a unique methodology that acknowledges the multiplicity of answers to the questions that drive research in that the variety of solutions and possibilities are endless. Adaptive Theory is sensitive to these possibilities and is capable of adjusting and modifying through analysis and interpretation of existing and new theory. This is where Adaptive Theory differs from grounded theory and phenomenology in that it encourages and can facilitate the combination of prior theory and conceptual elements that emerge from the data. In addition Adaptive Theory because of its ontological and epistemological stance (stratified and layered multiple realities) is particularly suited to researching aspects of social life that are reproduced over time (Layder, 2005). For example, the focus of the present study is empowerment/disempowerment while on clinical placement. The settings in the study are hospitals that provided clinical placements of undergraduate nursing students in the nursing profession. Within this setting many social norms and micro cultures exist that provide context and meaning to the study and augment the understanding of nursing student empowerment. Adaptive Theory acknowledges these influences and encourages the researcher to use this information during the process of analysis. Layder (2005) also acknowledged that the focus of the researcher may change within a study, from starting at the organisational level and shifting to the individual level. Balance is achieved by refocusing on a complementary set of concerns. The change in focus, however, should only be temporary, in order to facilitate analysis. In this study, while the immediate focus is the undergraduate nursing students’

empowerment, the focus may change when the organisational contribution is analysed in relation to the participants' empowerment. Again, deeper analysis is achieved through acknowledging that social life and system factors are intrinsically linked. This, Layder acknowledged (2005, p. 155), is the biggest difference between Adaptive Theory and grounded theory:

“The latter concentrates exclusively on the behavioural dimensions of social life while the former deals with both the behavioural and systemic aspects”.

Therefore it is suggested that in order to fully comprehend empowerment, it is necessary to explore it from multiple perspectives. Adaptive Theory facilitates this while acknowledging and building on previous theory on empowerment. The data in this study was therefore processed and analysed using my own knowledge and experience of undergraduate nursing student education. The employment of the Adaptive Theory approach therefore not only facilitated a wide breath of factors into the study, but enabled a richer understanding of empowerment because of their inclusion. Layder developed Adaptive Theory (1998; 2005) in order to respond to the gap that exists between general social theory and empirical theories (findings) and suggested that Adaptive Theory could bridge the gap. Social Domain Theory and Adaptive Theory accommodate each other in the generation of new knowledge.

3.5.3 Summary of Adaptive Theory

In this chapter the rationale for using Social Domain Theory (1998:2006) and Adaptive Theory (1998; 2005) are presented. Their relevance and suitability in exploring empowerment of nursing students' empowerment is discussed, together with demonstrating the depth of understanding their use in this study. Social Domain Theory has the capacity to capture the many facets of empowerment through its epistemological view of the social world. Adaptive Theory is an adaptable approach that can accommodate a theory such as Social Domain Theory, in order to facilitate deep analysis of the data as it emerges from the research. Layder (2006) encourages the dual influence of emerging data with extant theory which provides a rich understanding of the complexities of the social

world. In Adaptive Theory there is an acknowledgment of how the focus in a study may change during the research process as it is dependent on the data that arises from the study. In addition variations to the norm in terms of data are regarded of equal interest to the researcher and may according to Layder (2005) be as useful for understanding a phenomenon.

The following section describes in detail each part of the research process in this study.

3.6 The research process

Bowling (2009) described how the three tenets (ontology, epistemology and methods) are interrelated and interdependent. In order for the ontological objectives to be addressed, it is necessary to have the correct fit of methods and epistemological approach. This section of the methodology chapter describes how the study was conducted and includes sections that describe the study design, the sample, the setting, methods of collection and data collection process (Burns & Grove, 1999).

3.6.1 Data collection

In keeping with Adaptive Theory approach, data for this study data was gathered from the following sources: undergraduate nursing students, the literature and existing anecdotal knowledge. Layder (1998; 2005) maintained that the generation of new knowledge is shaped by existing knowledge and its dialogue with new knowledge. He (Layder, 1998; 2005) referred to this process as “theoretical scaffolding”, which refers to building on prior theory and research. The following section describes the data collection method used for this study (focus group interviews) and provides a defence as to why this was considered most relevant and appropriate approach.

3.6.2 Focus group interviews

Focus groups have been used in the social and behavioural sciences for more than 80 years (Redmond, 2009). The emphasis, with qualitative research, is on meaning, rather than measurement, and the focus group is an ideal method for gleaning an insight into a particular phenomenon. Focus groups are recommended as a method of data collection when little is known about a topic, or in the early stages of researching a topic (Barbour & Kitzinger, 1999; Steward et al., 2007).

3.6.3 Rationale for use of focus groups

A focus group can be defined as a small group of people who interact with each other and explore a pre-defined topic (Bowling, 2009). Kitzinger (1996) recommends the use of focus groups for ascertaining people's views on a particular subject, and why they hold such views. The focus group or "group interview" is popular because it offers the advantages of interviewing as well as the synergy of the group dynamic. Robson (2011) stated that an advantage of focus groups is that they present a highly efficient and effective way of gathering opinions from a number of participants. Parahoo (1997) contrasted the focus group with one-to-one interviews, where participants are serendipitously empowered by the process. Gomm (2008) and Kitzinger (1996) contend that it is easier for participants to disclose attitudes and practices in an environment that is open and secure with peers.

As with data collection methods, Lane et al, (2001) acknowledged that participants may tell the researcher what they think or believe he/she wants to hear. This was addressed in the current research, by explaining the need for honest and genuine thoughts and reiterating the confidential nature of the study. In addition, it was considered that as the participants are familiar with each other, they would be relaxed enough to discuss their experiences in relation to empowerment and clinical practice. All of the participants in the study were part of the same undergraduate class in general (adult) nursing, therefore they knew, and were familiar with, each other. Their views and experiences of empowerment/disempowerment were discussed through the use of focus groups, which included group dynamics and a discussion forum. Tracy (2013) advocates

that the *in vivo* characteristics of the focus group can be transformative for participants, in that they raise an awareness and understanding of important topics, as well as obtaining data for research purposes. As I was known to the participants and was employed in the nursing department as a lecturer the potential is recognised that participants may have felt coerced or powerless due to the power differential in the relationship between student and lecturer. However, focus groups provided a way of minimising the pressure placed on individual nursing students as they were in a group and individual pressure may have been lessened by virtue of the group situation. It was considered that one-to-one interviews would have been more stressful or intimidating for participants. Other steps employed to reduce participants feeling of coercion are addressed in section 3.7.4

A potential disadvantage of the focus group can arise where a dominant participant overshadows the contribution of other participants (Redmond, 2009). It is necessary, therefore, to be aware of this risk, and to manage the focus group so that all individuals are facilitated to contribute equally. In addition, some participants may require encouragement and sensitivity in order for their views to be elicited. It is acknowledged in the literature that facilitation of the focus group requires expertise (Kitzenger, 1995; Robson, 2011), and managing a group discussion requires skills and expertise, as the group dynamic may mean that those less vocal are not heard (Robson, 2011). As lead facilitator, I found that my prior experience in nursing and teaching was beneficial in the coordination and management of the focus groups. I was familiar with managing group discussions and including students into a group dynamic and this was to prove useful. In addition, an observer was employed to provide support and observe the participants' expressions and body language throughout the focus groups. The observer took notes throughout all of the focus groups.

The participants' familiarity with each other (over the four years of their programme) may or may not have been advantageous in the focus groups. Krueger and Casey (2000) urge caution in this regard, suggesting that pre-existing groups will have their own hierarchies and well-established dynamics. Conversely, Morgan (1998) suggests that focus groups encourage a higher degree of

spontaneity than other methods of data collection. As the literature suggests, empowerment is difficult to define (Chandler, 1992), and in anticipation of participants experiencing an initial difficulty in verbalising how empowerment is experienced, the group dynamic was felt to be an appropriate tool to aid discussion (Kitzinger, 1994). Indeed Fulton (1997), in a seminal piece of research on empowerment of undergraduate nursing students, found that focus groups were an effective method of data collection for his study. One- to-one interviews with nursing students may not have generated such a dynamic and consequently a debate on empowerment would have also had the disadvantage of reducing the number of participants in the study.

3.7 Ethical considerations

Following the recommendation of Johnson and Long (2006), a risk analysis was performed, to ensure that all ethical considerations are addressed for this study. This was helpful, as it facilitated reflection on any potential risks to the participants or their practice placements. All studies involving people and research carry an ethical risk, as there is potential for harm, distress and inconvenience for participants in electing to engage in the research process (Robson, 2011). The following section details the measures taken to ensure the safety of participants and full compliance with all ethical principles. This involved issues relating to informed consent, confidentiality, anonymity and the risk of coercion. The process of completing the ethical approval forms for this study is also described in this section.

3.7.1 Formal ethical approval

At an early stage in this study, ethical approval was sought from the following three sources: University of Salford, Waterford Institute of Technology (WIT), and Waterford Regional Ethical Committee South East. This process necessitated the completion of three ethical approval forms (one for each of the above), the submission of a research proposal (Waterford Regional Ethic Committee South East) and attendance at interview (WIT). The WIT research ethics committee highlighted the issue of dealing with an undergraduate nursing student population

and the associated power relationships for example, the potential for participants to feel coerced into participating in the study. In order to address this issue before starting the research, classes were organised so that I was not teaching the cohort involved (as stated in previous section). The research ethics committee stressed the need to emphasise to the nursing students that there would be no adverse effects for them disclosing information during the focus groups. It was explained to the nursing students that any reports of poor practice would be passed on to the appropriate clinical manager. This was documented on the participant information sheet (Appendix 1) and reiterated verbally at the beginning of the focus groups. Participants were also required to sign a consent form (Appendix 2).

The Waterford Regional Ethics Committee South East required that a change should be made to the participant information sheet, in order to make it easier to read and understand University of Salford University ethics committee suggested that amendments to the ethical approval form should include the following: details of anonymity provided to all participants; a reference to the availability of verbal information before written information on the study; and a statement to the effect that any disruption to the studies of the undergraduate nursing students would be kept to a minimum. Once these amendments had been made, full ethical approval was granted (Appendix 3).

3.7.2 Informed consent

Eliciting consent to participate in the study, and ensuring that the participants' consent is informed, is a fundamental part of ethical approval for any study (Robson, 2011). The first stage in gaining consent for the present study was to inform all undergraduate nursing students in the cohort about the study and its focus (i.e. undergraduate nursing student empowerment in clinical practice) during a timetabled study session organised by a college administrator. It was explained to the nursing students that their decision to participate in the study was entirely their own, and that there would be no negative repercussions for those who do not wish to take part. It was also highlighted to the students that, while an individual may initially wish to participate, she/he would be free to withdraw from the study at any stage. Written information in the form of a letter to students containing a

participation information sheet was issued to the students (Appendix 1). A return slip was attached to the study outline, and those wishing to participate in the study were asked to return this, indicating a desire to participate in the study. Following receipt of participation slips, a further discussion was held with those students who expressed a wish to participate in the study. Before obtaining written consent from those wishing to be involved (Appendix 2), I organised a 'Questions and Answers' session, where it was reiterated that their participation was voluntary and that they were free to withdraw from the process at any stage. Checks were made during and after the focus groups, to ensure that consent was ongoing, and to reassure participants that their participation and consent was a continuing process (Robson, 2011).

3.7.3 Confidentiality and anonymity

Confidentiality and anonymity are important ethical principles to consider in any study (Polit & Hungler, 1997). Confidentiality is concerned with not naming or revealing personal details of participants that might otherwise lead to their identification (Robson, 2011). All research participants have the right to anonymity, based on the right to privacy. In most studies, as in this one, the researcher knows the participants but promises to keep their identity and the data confidential (Burns & Grove, 1999). The following section provides an account of how confidentiality and anonymity in the study was addressed.

None of the electronic and paper data collected contained the names or placement details of the participants. A further consideration was that all discussions taking place in the focus groups would remain confidential, and that no breach of trust should occur. This is an essential factor, to assure participants of confidentiality, while guaranteeing that they have the freedom to speak and express their views. Equally, participants need to be mindful that they do not discuss the content of focus group with those outside the focus group. This was emphasised to all participants at the beginning and at the end of all focus groups. It was necessary also to explain in full to the participants how the code of ethical practice works, in relation to the researcher's confidentiality, and that of the clinical placement.

The audio tapes and transcripts were stored in a locked cabinet within a locked office, and on password encrypted computer. Access to the data has been limited solely to myself and my supervisors. In keeping ethical approval guidelines and with data protection legislation, all primary data will be destroyed and shredded after the lifetime of the study. An assurance was given to the ethical committees and participants regarding the confidentiality and anonymity of data in this study. Furthermore, the observer was deliberately selected as she was not known to the participants. It was hoped that this would increase the confidence of the participants in the anonymity of the study and the in the research process, by ensuring that they felt safe in the environment to discuss their empowerment in clinical practice. All participants were given a choice as to where was most convenient for them to participate in the focus group. Participants chose the hospital setting (clinical placement) as it was convenient for them while on clinical placement. Because the participants chose to have their focus groups in the hospitals where they were assigned to (clinical placement), all focus groups were hospital specific. This changed the dynamic of the focus groups, as pre-existing groups used for academic course work were not used, and students were placed in a focus group with fellow students with whom they were not familiar. A quiet and private room was organised by hospital staff to run the focus group interviews, where participants were not at risk of being overheard or disturbed.

A concern raised by the male participants was that they would be recognised in the transcripts. This was perhaps due to the small number of males on the programme. I acknowledged this concern and in an effort to appease their concern deliberately removed any reference to gender throughout the transcripts. This was done to afford the male participants the highest level of anonymity.

3.7.4 Coercion

Coercion is defined by Cohen et al., (2008) as being compelled by force or under pressure to participate in research. The target population is undergraduate nursing students in their final year of nursing. In order to address this potential risk, I requested not to lecture or examine any academic work from the sample in

order to reduce the contact I had with the cohort as a lecturer. It was also emphasised to participants, on numerous occasions throughout the process, that there would be no negative repercussions for refusal to participate in the study or for withdrawing from the study during the process. As I worked as a lecturer with the nursing students an imbalance of power may have been perceived by the participants and this has to be acknowledged. Therefore, I organised through the Head of Department that I would not be teaching or involved in the assessment of this cohort (nursing students involved in the study) and this information was conveyed to the participants. This was addressed in acknowledgement of the potential for participants to feel coerced into participating in the study. In addition participants were reassured and their prerogative to withdraw from the study reiterated in order to address the power imbalance.

3.7.5. Securing access to sample

As the participants were on clinical placement at the time of the study (internship of 36 weeks' clinical placement in final year), permission was required from all of the Directors of Nursing in the various hospitals to allow access to the undergraduate nursing students. A letter requesting permission to enter the various clinical sites was sent to the Directors of Nursing in all four hospitals (see Appendix 4). This letter outlined the aims and objectives of the study, together with details of what it entailed. Permission to conduct the study was received from all four Directors of Nursing providing access to the participants once full ethical approval had been received.

3.8 Sample

According to Polit & Hungler (1997), the sample for qualitative research should be capable of providing meaning, and uncovering multiple realities of the phenomenon of interest. Studies in qualitative research tend to use purposive samples in preference to random samples, in order to fulfil the researchers' requirements (Miles & Huberman, 1994). Furthermore, Sandelowski (1991) suggests that the researcher strives for data richness in the sample rather than size. As the focus of this study was (a) to identify what nursing students

understood by empowerment and (b) to ascertain the factors that impacted empowerment during final clinical placement, it was important that the participants should meet the following criteria: be advanced in the nursing programme, and in be in clinical practice some time before and during the time of data collection. Students of psychiatric nursing, midwifery, children's, and intellectual disability were not included in the study, as all programmes use different curricula and differences in empowerment might have been influenced by the different curricula rather than the clinical placements. It was therefore decided to use the nursing students from general (adult) nursing as this formed the largest group.

This study was conducted in Ireland, within a group of hospitals that provide placements to undergraduate nursing students. A purposive sample of 45 undergraduate nursing students was used. This sample comprised all of the undergraduate nursing students in the fourth year of the undergraduate programme for general (adult) nursing. The following section details how access to the sample was obtained.

3.8.1 Developing a sample

Choosing a sample in any research study is an important part of the process. For this study, like many other qualitative studies, it was important to select a group of participants who were "*information rich*" (Layder, 2005, p. 46). This method of sampling is known as purposive sampling (Miles & Huberman, 1994). There are, however, many subtypes of purposive sampling, including: theoretical sampling, homogenous and heterogeneous sampling, and extreme case (deviant case) sampling. In contrast with Glaser and Strauss (1967), Layder (2005) recommends that theoretical sampling must be "true" theoretical sampling, and suggests that it needs to include new people, prior theory, data collection, and data analysis in order to conform to Adaptive Theory.

A convenience sample of 45 fourth-year adult undergraduate nursing students was selected and invited to participate in this study (this was the total population of available nursing students in the cohort). The sample selected is homogenous, in that certain disciplines of undergraduate nursing students at the fourth-year

stage (psychiatric, midwifery, children's and intellectual disability disciplines) were excluded. It was thought that this should reduce any variations in findings that may have been attributed to discipline focus and differences in curricula and placements (Polit & Hungler, 1997).

3.8.2 Recruitment of participants

Layder (2005) views theoretical sampling as being concerned with more than just the sample, but also with the integration of any existing literature or theory, or theoretical frameworks as sources of evidence and information. He further describes this (2005, p. 47) as having a “*dialogical*” relationship between existing and previous theory, data collection and analysis. Layder (2005, p. 48), for example, believes that this:

“Enables a proper treatment of issues of power, control and domination, and the resources that underpin them (including the analysis of ideology and other cultural discourses”

A key finding following the review of international and national literature on empowerment was that many studies have focused on either organisational or psychological approaches to empowerment. Those focusing on mixed approaches used quantitative measures that failed to take into consideration other factors such as education, culture and power in the environment. This impacted the sample selection process, as it was the focus of the study to elicit the views of nursing students in their final year. In addition my role and knowledge is also recognised and Layder's Adaptive Theory supports the inclusion of the researcher and suggests that this augments and makes the process more authentic:

“Thus Adaptive Theory represents a methodological approach which takes into account the layered and textured nature of social reality (its ontological depth). It also acknowledges the need for an epistemological basis which reflects the interweaving of objective and subjective elements of social life.” (Layder, 2005, p. 27)

Through using Layder's Adaptive Theory in the present study the undergraduate nursing students are deemed “information rich” and an appropriate sample for this

study. The nursing students in this study were in their final year of a four-year nursing programme in adult (general) nursing. During this year, 36 weeks were spent in the clinical area on placement within one hospital. Data collection for the study did not commence until nursing students had completed 12 weeks of the internship programme, in order to provide them with an opportunity to settle into their environment.

3.8.3 Selecting participants

In order to explore the empowerment or disempowerment of undergraduate nursing students, it was desirable to have as many views as possible from the entire group. The entire nursing student cohort was informed of the study during a timetabled information session (45). This was organised by a college administrator on my behalf. All of the students were given information about the study in both verbal and written format (Appendix 1), including details regarding confidentiality and data storage. An opportunity to ask questions was provided during this session, and the undergraduate nursing students were advised that there was no pressure on them to participate in the study, nor would there be any adverse consequences for failure to take part. Consent forms were distributed to fill in at a later date.

Consent forms (Appendix 2) were collected two weeks after this briefing session, and a specific collection box was placed in a prominent area for nursing students to submit their signed consent forms. Those who consented to participate in the study were asked to attend a second timetabled session (also organised by a college administrator) to facilitate any further questions or concerns they may have had after having a period of time to reflect on their decision to participate. At this session, the participants were given a choice of where they would like the focus groups to be conducted.

3.9 Focus groups

The size of the focus group is an important consideration. Some authors suggest that 6-10 is optimum (Morgan, 1998; Bloor et al., 2001). Tracy (2013) suggests using as few as 3, and a maximum of 12, the ideal range being 9-12 participants. However, on the day a number of variables can affect the size and so over recruitment, in order to counter the risk of non-attendance is another strategy recommended in the literature (Morgan, 1997; Redmond, 2009; Tracy, 2013). Morgan (1997) recommends over recruiting by as much as 20% to ensure sufficient attendance. Corbally et al. (2007) in an Irish study of registered staff recruited 14 participants to each focus group. Parahoo (1997) comments that, while size is an important issue in focus groups, it should not be the starting point; rather, the purpose for which the participants are recruited should determine the number of potential participants. Out of a population of 45 the sample size was 43 as two nursing students did not attend any of the scheduled focus groups despite initially agreeing to participate in the study.

3.9.1 Focus group question guide

Drawing on the literature on empowerment of qualified nurses, a focus group question guide was developed to aid the facilitation of the focus groups (Appendix 5). Robson (2011) suggests that typically fewer than 10 questions can be asked in an hour. The sequencing of the questions is important, and those questions requiring more thought and introspection should be left until the participants become more vocal and relaxed. Following a pilot focus group, the sequencing of questions was amended to increase participation, as it was found that participants needed an opportunity to relax and settle with each other and their environment before discussing the concept of empowerment (Appendix 5). Therefore, some warm-up questions and techniques were used. These involved asking students about settling into the clinical areas and general questions about their progress on the programme.

3.9.2 Pre-focus group planning

The choice of venue to conduct the focus groups was left to the participants to decide. All participants requested attending the focus group in their hospital setting, for convenience. Clinical placement coordinators (student support while on placement) helped coordinate the logistics of the focus groups. All participants were informed at the beginning of the focus group the purpose of the study, and reminded about the ethical principles, including the right to withdraw from the study at any stage should they so wish, and the necessity of confidentiality. Any questions were answered for participants and verbal consent was obtained to proceed with an audio-taped focus group interview. A short form outlining the demographic details of the participants was completed, to provide background demographic information such as age, sex and category (mature or school leaver) that might be considered relevant at a later stage (see section 4.1 Table 4). In two instances participants did not specify male/female; these are described as unassigned in Table 4. The undergraduate nursing students were also informed that the data would form part of the doctoral submission and could potentially be used for conference presentations or publications. It was reiterated that anonymity of the practice placement and participants was ensured.

3.9 3 Facilitation in the focus groups

It is acknowledged in the literature that, while not requiring formal training, the facilitator does require good interpersonal skills (Morgan 1998; Krueger, 1994). Initially it was important that I should consult with other more experienced researchers, from whom I gained much insight into the organisation and facilitation of the focus groups. The help and support of my research supervisors was invaluable and encouraged reflexivity and deeper analysis throughout the process.

In addition, as an experienced nurse and lecturer, I found that facilitating groups and eliciting answers to the research question was within my own area of expertise. An observer (a PhD student with interview experience and from a nursing background) performed memo taking during the focus groups. In addition, the observer's focus was on watching the dynamics between the participants,

taking notes on body language and facial expressions during the interviews, and observing the interaction between participants, such as signs of unease, fidgeting and other behaviours. Sim (1998) recommends this approach during qualitative interviews, as the observer can pick up any undue prompting by the researcher. The role of the observer was to ask questions and, if necessary, seek clarification. The same observer was available for all the focus groups, which was advantageous as she became familiar with the topic and format.

3.9.4 Managing the group dynamic in focus group interviews

Interaction between the participants is a key aspect of focus groups (Bloor et al., 2001). This is why a homogenous group of adult undergraduate nursing students was selected for the study. Morgan (1998) explains that the participants need to feel comfortable together in order for the dynamic to be favourable. The dynamic however is also acknowledged in the literature as an advantage, as it provides a quality control and helps to focus the discussion (Robson, 2011). This validation and discussion can lead to the development of patterns and themes about the empowerment/disempowerment process.

The participants in this study were used to being in a group situation in their class for academic work in college, and were therefore confident and comfortable together for the purpose of the focus group. This was viewed as a positive factor, especially in relation to asking them to recall and recount incidences of empowerment/disempowerment. As a way of addressing Krueger and Casey's (2000) concerns that familiarity in focus groups may inhibit participants divulging incidents that may be sensitive or cause embarrassment, previous study group formations were altered so that, although there was familiarity between the participants, particular groupings were based on the participants' clinical placements, rather than academic study groups.

Throughout the focus groups, the role of the observer was to remain focused on ensuring that all members of the focus group were provided with an equal opportunity to contribute, that inconsistencies were explored, and that members of the group were encouraged to think and theorise about empowerment.

3.9.5 Focus group administration

Each of the focus group interviews was scheduled at a venue selected by the group that was most suitable for them. In advance of the focus group interviews, the rooms were prepared. This entailed organising the seating area in a circular arrangement, and the provision of refreshments for the participants, both during and after the focus groups.

At the start of the focus groups, all participants were welcomed and thanked for participating in the study. An outline of the study was provided to the participants, together with its aims and objectives, and they were reminded that all of the data would be treated confidentially, and that the anonymity of the participant and the hospital placement would be maintained throughout the study. Participants were asked to give their verbal consent to participate in the study and it was reiterated to them that they were free to withdraw, without any repercussions, at any stage during the process. The observer was introduced to the participants, and it was explained that she would observe and take notes throughout the focus groups. All participants were informed that the interviews were audio recorded and that they would have an opportunity to listen to the interview at the end of the focus group, should they so wish.

The visible presence of the audio equipment may be perceived, during the focus group, as being a barrier to open discussion, and therefore not conducive to participation. Therefore it was placed out of the line of vision, to put the participants at ease, and to encourage the flow of conversation. Also, in order to make the participants feel comfortable at the start of the focus groups, the audio equipment was turned on and this was followed by a period of general conversation about placement and hospital life. Once everyone appeared to be conversing at ease, I was able to guide the participants in a more natural way towards to subject of empowerment during clinical placement.

The focus group guide helped by providing structure at the start of the interviews, but once the participants started talking and thinking about empowerment it became less valuable. At the end of the focus group interviews all the participants were thanked and provided with information regarding the completion timeframe.

3.9.6 Concluding thoughts on focus groups

Consistent with research regarding the value of focus groups (Gale, 1992; Owen 2001), the participants found that it was helpful to talk about how they felt. They said that they did not realise that others felt the same, and made them feel better to talk to others, who understand, about how difficult and challenging it can be sometimes be. They suggested that assertiveness training would help them be more prepared for the clinical environment. Empowerment and disempowerment, they felt, were important issues for nursing and they enjoyed exploring the concepts during the focus groups. One of the benefits of the study was that nursing students accepted that it was “ok” to feel the way they did, and that others felt the same. Participants discussed the pressure they were under and how they tried to support each other during placement. Participants in all focus groups expressed that they felt more relaxed following the focus group, and it appeared that they were. Through facilitating the conversation about how they felt and their empowerment/disempowerment, they felt less alone and that they had more in common with each other.

3.10 Data analysis

In the last section, a detailed discussion on the methodological and philosophical approach used in this study was presented. This section considers how the data from this research was analysed. According to Elo and Kyngas (2007), numerous approaches can be used for the analysis of qualitative data. The selection of an approach to analysis is dependent therefore, on the study in question, the researcher’s preference, and the methodology.

3.10.1 Introduction to data analysis

Content or thematic analysis is a form of pattern recognition that is based on reading and rereading the data (Fereday & Muir-Cochrane, 2006). Content or thematic analysis has a long history of use in sociology, psychology communication, business, and nursing (Elo & Kyngas, 2007). Many nursing studies using qualitative data employ a thematic analysis as a method of

analysing the data through its systematic and objective approach (Elo & Kyngas, 2007). In this study, NVivo 10 was used as an electronic aid to help with data analysis as it can provide a single storage location, easy access to data and improved consistency in approach to analysis (Bergin, 2011). However, it is worth bearing in mind, as Gibbs (2004) comments, that it is not the computer that interprets the data but rather the researcher.

3.10.2 Adaptive Theory's approach to data analysis

Adaptive Theory was used in conjunction with Social Domain Theory in this study. Layder (2005) developed Adaptive Theory in order to provide a flexible process and structure for data collection and analysis that is compatible with Social Domain Theory. The three core concepts of the Adaptive Theory approach are:

(1) It is impossible to “*start from a clean slate*” (Layder, 2005, p. 51), therefore it is important to acknowledge one’s own theoretical assumptions (including prejudices) in order to facilitate more powerful explanations from the data (Layder, 2005) (see section 1.6 and section 3.13).

(2) The “adaptive” part of the theory relates to the theory’s ability to respond to incoming data as well as data that was previously available (i.e. the literature, historical legacy, cultural influences); and

(3) Pre-coding and provisional coding are retained throughout the analysis and dialogically engaged with emergent and extant theory and materials (Layder, 1998; 2005).

Throughout the thesis, reflective sections include sections detailing my thoughts and feelings referred to as ‘the researcher’s voice’ to help inform the reader of the thought processes and reflections that formed part of the study. Layder’s Adaptive Theory (2005) fully supports the inclusion of the researcher in the process. In the findings chapter literature that was consulted throughout the data analysis is referenced as this also influenced the analysis through Layder’s (2005) acknowledgement of the importance prior theory and literature.

For this study, a cyclical data analysis approach was used, guided by Adaptive Theory methodology (Layder 1998; 2005). Other similar approaches were considered, such as those proposed by Elo and Kyngas (2007), and grounded theory (Glaser & Strauss, 1967). However, the Adaptive Theory method of data analysis provides a comprehensive and flexible framework that is capable of answering the research questions in this study. It also provides a framework within which deep analysis was facilitated through acknowledgement and recognition of the cultural and historical influences of the clinical placements. It does this by acknowledging the multiple factors that influence our social reality. For example, power is present in all social domains and impacts analysis and meaning derived from the focus groups (see section 2.4, and, section 3.4). The following section details how the data in this study was analysed using a cyclical approach guided by Adaptive Theory.

Step 1: data collection

The first stage of the cycle is concerned with the process of data collection, as described in the previous section, and the data was collected from different focus group interviews. Audio data was transcribed *verbatim* into a word document, in preparation for data analysis, and then transferred to the electronic data management system, NVivo 10. It was then listened to and read, in order to facilitate familiarisation with, and emersion in, the material. Listening to the data, reading and rereading, ensures that the real meaning of the transcripts will not be lost at any stage in-order to remain true to the data.

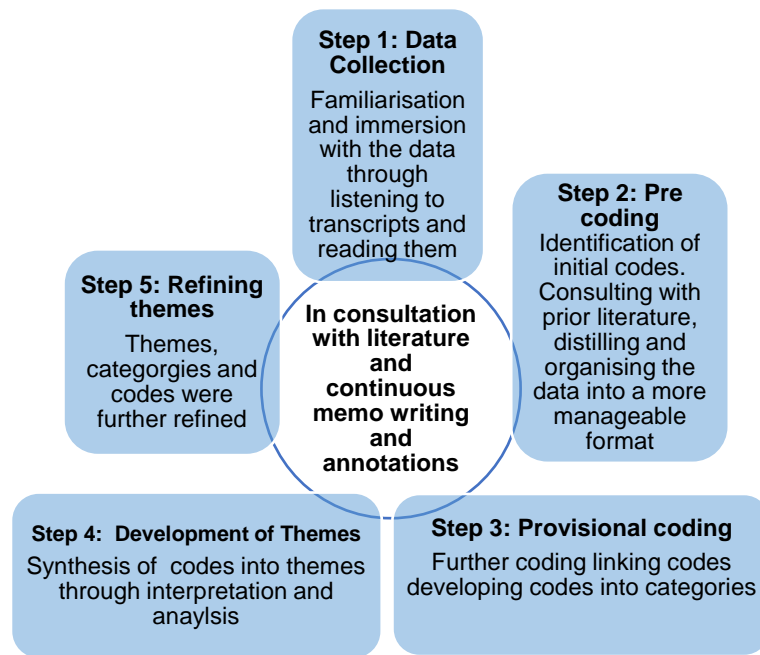


Figure 1: Adapted data analysis process Layder (2005)

Step 2: pre-coding

The next stage is known as pre-coding, which is where segments and sections of data that have meaning and relevance (Layder, 2005) are identified from the transcripts, and assigned a provisional code, which may or may not be changed at a later stage. It should be noted that it is not necessary to code the entire transcripts line by line, but rather provide the meaning. In this study each interview was transcribed *verbatim*.

Pre-coding is emphasised by Layder (1998; 2005) as a way of creating new codes at an early stage in the data analysis, and is frequently referred to as in research literature as “open coding”. At the pre-coding stage, segments of text were coded to reflect that they are sections with possibilities and potential later on in analysis. Robson (2011) states that there is no agreed approach in data analysis, as there are so many different methods. For example in grounded theory, the researcher begins from the individual case and slowly and systemically builds into categories and theories (Tracy, 2013).

In Adaptive Theory, Layder advocates the use of prior theory at this stage to organise the data and to stimulate theoretical thinking (1998; 2005). There are no fixed numbers of codes that should emerge with Adaptive Theory, and it is entirely dependent on the researcher and the data. Layder (2005, p. 55) states:

“In this sense what I have termed pre-coding or provisional coding should be retained throughout the analysis in parallel, and dialogically engaged with, both emergent core concepts and the extant theoretical materials.

Such a standpoint has two advantages over the procedural sequence advised by grounded theorists. First, the idea of the continual receptiveness of the research to new codes (and hence novel theoretical ideas) means that there is no wastage produced by the closure of the emergent theory within and around the core categories that emerge in situ.

Secondly, the idea that pre-coding and provisional coding always take place in the context of a dialogue with emergent theory and extant theory (including general theory) ensures that emergent theory is not cut-off or isolated from the ongoing established body of theoretical concepts and ideas (both classical and contemporary).”

During the pre-coding phase of the current study, initial codes were developed. Using NVivo 10 to perform the pre-coding phase helped to manage the data. NVivo 10 has its own terminology for each phase of the coding process. Within NVivo 10, coding the data involves the creation of nodes. A node is a collection references about a particular theme or an area of interest (Bazeley, 2007). Within NVivo 10, these nodes are referred to as free nodes, tree nodes, case nodes, relationship nodes and matrices (Bergin, 2011). For example, with tree nodes there is a hierarchical structure starting with the parent and moving to the child corresponding with moving from a general theme to a more specific aspect of that theme. Case nodes are concerned with participant attributes such as demographic details. Relationship nodes define a relationship between two or more nodes. Finally, matrices are the result of a matrix-coding query that is used to further explore relationships between nodes. This NVivo 10 “language” and system was compatible with any methodology, and its main benefit is that it facilitates interrogation of the data through the use of query tools such as matrices that would otherwise be more difficult (Bergin, 2011). The remainder of this section discusses the data analysis using the terminology of Layder (2005), to avoid confusion of using both sets of terminology.

Step 3: provisional coding

Pre-coding leads to provisional coding that results in the provisional codes being merged into categories by ongoing data collection and analysis. Some of the initial codes were merged and changed during the course of refining the analysis. This stage is done in dialogue with contemporary and empirical literature. Further coding was performed at this point, linking codes and themes and providing segments of text with classifications to provide more focus. This helped to provide direction to the analysis, by highlighting relevant questions that might be asked of the data.

Ultimately these codes become categories. In the final stage of analysis, themes are developed from categories and codes. Broad themes were refined into themes and sub-themes. Throughout this process, memos and annotations ensure continuous dialogue with prior theory and literature. This means that I, , was continuously open to the idea of new codes and theories throughout the process of data collection and analysis. Through the identification of core and satellite codes, it is possible to identify significant chunks of data through classification of labels and apply them to particular sections, still acknowledging prior theory and knowledge (Layder, 2005). This gives focus and direction to the analysis by highlighting relevant questions that one may ask of the data. During the analysis, these terms will have personal meaning and will be clear only to the researcher (Glesne & Peshkin, 1992). However, at a later stage these links and codes can easily be transformed into coherent codes that have meaning and relevance. Again at this stage, prior theory and concepts are not disregarded, but rather they are acknowledged as having a place in the process, while not being regarded as sacrosanct (Layder, 2005).

The combination of coding and memo writing helps to reduce the volume of data into more manageable pieces. This entails continuous interrogation of the data to discern meanings, and to produce ideas and explanations for the “so what?” and “how?” questions. Layder (2005) suggests that they are a way of exploring whether or not codes, concepts and categories are really illustrated in the data. Burnard (1991) describes memos as a way of categorising the data and, as the

name suggests, they serve as memory-joggers to record ideas and notes as the researcher is becoming immersed in the data. The use of a reflective diary throughout the process of data collection and analysis was helpful in terms of developing reflectivity. A reflective journal containing memos was kept throughout this process and consulted throughout various stages of analysis to stimulate and clarify thoughts and analysis. 'The researchers' voice' sections at the end of each chapter reflect the content of the reflective diary.

Layder provides a structure in Adaptive Theory which was used in the present study in analysing the data. However an additional step of refining themes (step 5 Figure 1) was added modifying Layder's theory for use in this study. This provided me with another opportunity to analyse and confirm representation of the data gathered in the focus groups. Also as the volume of data involved in the study was large it also served as a further verification of the analysis to date.

Step 4: Development of themes

The use of memos to add depth of meaning to the analysis can take place at each stage of the process, or as required. This provides a trail to follow the development of thought and new theories within the study. Memo writing provides an opportunity for discussion with the data in order to explore if concepts, codes and categories were really illustrated in the data. For this study, memo writing was ongoing throughout the process of data analysis. The development of themes at step 4 with categories and codes supporting the analysis can be seen in. At this stage of analysis one focus group appeared different from the others (focus group 2). This group was identified as being a deviant group. Miles and Huberman (1994) and Patton (1999) describe the *deviant case* or *negative case*. Patton (1999) suggests that the quest for the deviant/negative case that does not conform to others or appears to be different is an important part of analysis in data analysis. On further analysis it became apparent why this may have been the case and this is discussed in section 4.3.3. Layder (2005) suggests that any deviation from the norm in data analysis requires the same consideration as the rest of the data (see section 3.5).

Step 5: Further refinement of themes

According to Layder (2005), synthesis of themes from the categories of data, in consultation with the multiple sources, methods, strategies and types of data, creates a synergy, and encourages theory development. Layder (2005, p. 77) refutes the idea that theory simply “*emerges from*” the data, and encourages the pulling of strands, and the establishment of connections within the data. In consultation with the literature and the data, themes are then generated. This step of the data analysis process for the current study involved the developing of broad themes, with the additional step added in order to further refine themes and categories. Figure 1 demonstrates the process of data analysis according to Layder (2005) and pre-empted the findings of the study by providing an example of how one of the participant’s views contributed to the study and how the coding process worked using one sentence as an exemplar. It is clear that many of the pre and provisional codes could have been coded to many of the codes/categories and themes. For example ‘sometimes staff are not really nice to you’ was coded to several codes (attitude to students, disempowering preceptors’ relationships, respect). Through the various stages of analysis it became clear where it belonged and how it fitted into the picture as it unfolded. Polit and Beck (2004) suggest that this stage is to be expected and part of the process in qualitative analysis.

Table 3: An example of data analysis drawn from the study

Step 1: Data collection

Data was read and listened to it was then transcribed *verbatim* and imported into the NVivo 10 software. The following provides an example of one participant’s views and demonstrates how one sentence can contain themes and sub-themes. Each theme is demonstrated in colour to aid clarity in the example.

Step 2: Pre-coding (identification of initial codes)

The following section of text was assigned and coded to the provisional coding theme of “culture”.

FG 3 Ref. 4 *It’s easy to be nice to the patients and it’s hard to be nice to the*

staff sometimes when they're not really nice to you. We're still students. We have to get through our placement so it's all okay and smiles thank you.

Step 3: Provisional coding (linking codes into themes)

The segments of text below were assigned to the following codes and then into categories on further analysis. These were merged and altered into themes with sub-themes with further refinement and analysis.

Nursing culture

("Sometimes when they're not really nice to you"

"it's easy to be nice to the patients)

Evidence of student's self-worth/nursing student's self-perspective

("it's hard to be nice to the staff when sometimes they're not really nice to you"

"We're still students")

Power/disempowerment

("We have to get through our placement")

Socialisation

"It's all okay and smiles thank you".

Step 4: Development of themes (synthesis of themes through further analysis)

Theme: culture and socialisation

Organisational /hospital / macro culture

Ward / unit/ micro culture

Effect of preceptors

Preceptors attitudes to students teaching and learning

Process of fitting in on a ward

Step 5 Refinement of themes (themes and categories further refined)

Theme 1: **culture**

Organisational /hospital **culture**

Ward /unit **culture**

Theme 2: **Socialisation**

Settling in

Chameleon phase

Theme 3: **power/powerlessness**

Nursing students perceptions of power and powerlessness

3.10.4 Mind map used to conceptualise data

Another way of conceptualising the data that was useful in the study (although not specifically recommended by Layder, 2005) was the development of a mind map (Appendix 6). This was useful at several stages of the analysis process as it clarified my thoughts and helped to map out codes, categories and themes. Layder (2005) does not discuss the use of mind maps and so this is an amendment to the original theory. However Brightman (2003) advocates their use as a tool of personal knowledge and exploration, reflection and learning. This example of a mind map shows the development of a theme of culture running throughout the analysis phase.

Organisational and ward culture are sub-themes of culture. In organisational culture, a broader perspective is provided by participants as they experienced it. The governance of all the clinical sites involved in the focus groups was under the control of the Health Service Executive (HSE) as discussed in section 1.2.2. Quotations are provided to demonstrate how the participants felt in relation to the organisational culture. The ward or unit culture contained many other codes, as described by the participants. These include: the support provided by preceptors, attitudes of preceptors, inclusion and belonging. These codes were coded on to different nodes and codes to become sub-themes accordingly, as the data was distilled down. The mind map (see Appendix 6) provides an audit trail of the theme of culture with supporting quotations that show how the development of analysis through pre-coding, provisional coding and the development of themes with sub-themes.

3.10.5 Coding in the study

The practical example provided in Table 3 demonstrates that within one sentence there are a variety of themes and sub-themes assigned to each unit of meaning. The distilling down of large chunks of text into units of meaning and the organisation of these units into themes and sub-themes using Adaptive Theory (Layder, 2005) is depicted in the coding book (see Appendix 7). This coding process demonstrates how one sentence could also at the provisional coding

steps be assigned to more than one theme. For example “it’s hard to be nice to the staff” could be a cultural theme or it may fit under socialisation. In the coding book (Appendix 7) each of the codes assigned on the second step (first step is familiarisation and immersion in the data) of coding is displayed. The coding book shows the number of focus groups coded and the number of times each unit of meaning is coded. This demonstrates the depth of coding and also shows how the large volume of data is distilled down to three themes and a variety of sub-themes.

3.11 Computer-aided data analysis package – NVivo 10

Data analysis for this study was facilitated through the use of a data management system known as NVivo 10. Computer-aided qualitative data analysis systems (CAQDAS) are recognised globally for supporting the management of qualitative data. In using NVivo the analysis is performed, as described below, while the computer package facilitates data storage and retrieval. Elo and Kyngas (2007) suggest that reporting and presenting results of qualitative studies is recognised in the literature as being challenging, and recommend data analysis software programmes to help with the process. NVivo 10 is a specialist package that was developed by Professor Lyn Richard to support researchers in their analysis of data using qualitative approaches. An advantage of a data analysis programme is that it facilitates the researcher in mapping relationships on screen (Denzin & Lincoln, 2011; Bergin, 2011). Richards and Richards (1994) suggest that the code-and-retrieve method supports the emergence of theory. Pope et al. (2000) state that a package can replace the researcher’s role of perceiving a link between theory and data, as well as defining an appropriate structure for analysis, which could be viewed as a disadvantage. This was not the case in this study: by using a well organised computer-aided system (NVivo 10), I was able to clearly see links in the data that would not have been possible using more traditional methods.

Therefore, the two of the main benefits of NVivo 10 are efficiency and transparency. Ease of navigation is a further benefit, together with the facility of listening to the actual interviews while reading and highlighting the transcripts. Another benefit that NVivo 10 provides is that all the data can be digitally recorded

and interviews can then be imported and transcribed. It is also possible during analysis, as well as rereading the text, to listen to the interviews again, thereby eliciting a deeper meaning and gaining a better understanding of the participants' perspective.

3.12 Changes during the study

Initially it was my intention to use a range of methods to collect data for this study, including a questionnaire to measure empowerment, and focus groups to discuss the process of empowerment with nursing students. Following an interim review and viva discussion held with the internal examiners in University of Salford (October 2012), the merits of the quantitative approach were questioned. As a previous study using a questionnaire showed nursing students in Egypt to be moderately empowered (Ibrahim, 2011), a suggestion was made to proceed with a purely qualitative study. Initially ethical approval had been sought and given for a mixed method study. After some consideration, the decision was made to proceed with a qualitative study using focus groups, and the necessary amendments were made to the existing applications for ethical approval.

3.13 Researcher's Voice

In keeping with Layder's methodology and approach to research (as detailed in section 3.4), prior knowledge and experience are acknowledged throughout the study. Layder's theory acknowledges that it is impossible to start from a "*clean slate*", so it is honest and authentic to acknowledge one's background and experience. Therefore (see section 1.9), from a naturalistic and epistemological perspective, I as the researcher have no issues regarding objectivity once my position is declared and stated. The findings of this study are the by-product of analysis performed by me as the researcher and therefore cannot be divorced from my experiences as a clinician and educator.

In view of this, the following section details my reflections as a researcher and nurse following the conclusion of the focus groups. Meeting the nursing students and discussing their clinical placements and empowerment was very interesting

for me as a nurse and educator. It never became boring or monotonous. Each student group was anxious to talk, and appeared to speak openly and honestly about their experiences. Their demeanour was friendly and enthusiastic. All of the focus groups were facilitated by myself and an MSc student who was not known to the students (an observer). The role of the observer was to provide great help, as it provided another perspective. The observer's notes together with audio and written transcripts provided a detailed account of facial expression, intonation and the written word. Jackson (1988) recommends that this triangulation of data adds to the richness of qualitative data in focus groups as the uniqueness was in the interaction of the group. It also provided a support to me as the observer was someone with whom I was able, to discuss and consider the experiences of the participants. As she was from a nursing background, and an experienced and insightful nurse and educator, I trusted and benefited from her presence throughout all of the interviews.

Throughout the focus groups, I experienced many different emotions from joy to sadness: sometimes there was great hope and energy, and on other occasions the participants appeared tired of trying and drained of energy. A predominant feeling that I associated with data collection was a feeling of pride in these young individuals who were confident and articulate enough to describe how they felt empowered and disempowered, thus contributing to the research process.

Occasionally, I felt saddened; provoked by the level of disempowerment experienced by the participants and the way they described it. They were familiar with the experience and "struggle" of disempowerment and consequently, if they were not struggling with feeling disempowered at the time of the focus groups, they had experienced periods of disempowerment previously throughout their clinical placements and so they could relate to it. Participants detailed their incidences of disempowerment unaware of the impact they were having on me, as they did not see their experience as unique or worthy of sympathy. However, I thought that the disempowering experiences they encountered were very disappointing from the perspective of being a nurse, and felt sad for nursing students who need to be empowered in order to practice nursing at their optimum. This feeling was momentary and transitory during the data collection, but would

reappear on analysis and on the writing up phase of the PhD project. My colleague who acted as observer also experienced a similar reaction, so we could discuss this and reflect on it.

I was also during this time shocked by how little I knew of the plight of the nursing students. I would have considered myself to be a very student-centred member of academic staff, with many years of experience in both nursing and supporting nursing students, in various positions. However, the exposure over a period of a few months of data collection, followed by numerous months of data immersion and coding, had a significant impact on my understanding and appreciation of the plight of nursing students. This cohort of mainly young people experienced providing care for members of the public in what is a challenging environment, and furthermore, had the pressures of academic college life. I can think of no other profession that demands such standards from its learners so early on in the profession. I am also cognisant, through my own professional experience, that fellow colleagues like me perhaps do not consider the challenges that students very often face.

I noted and felt no reluctance to describe empowerment or disempowerment from the focus groups. This I attributed to having had distanced myself from that cohort in advance of the study and so had not an active role with them in terms of assignments or teaching. This was corroborated by the observer.

3.14 Chapter summary

This chapter has presented the theoretical and philosophical foundations for this study. It has considered various research philosophies and theories and discussed them in light of the research aims and questions. A variety of philosophical approaches are discussed and Layder's Adaptive (2005) and Social Domain Theory (2006) are selected as being the most suited to the study and my own philosophical stance. A justification for the selection of Layders' Social Domain and Adaptive Theory is presented and justified. This is followed by a description of the key tenets of both theories Adaptive (2005) and Social Domain (2006). The research methods are presented providing detail on ethical approval,

sample, data collection and data analysis. Any changes that occurred during the study are discussed and followed by a reflective section that provides insight into my thoughts and feelings during this stage of the process. Finally the chapter concludes with a chapter summary.

The following chapter - Chapter 4 - reports on the findings of the study.

Chapter: 4 Findings

4.0 Introduction to findings

The previous chapter described how data analysis in this study was planned and carried out using Layder's Social Domain Theory (2006) and Adaptive Theory (2005). It detailed the ontological and epistemological influences and discussed how Layder provides a methodology that is capable of framing empowerment within the participants' social world. In addition, the social domains acknowledged the influence of society, culture, organisations and individuals within one's social world and therefore facilitated the analysis of empowerment at this deep level (see section 3.4).

This chapter presents the findings of the present study. The primary focus of the study was to explore undergraduate nursing students' experiences in their final year clinical placement in relation to empowerment or disempowerment. This was done through the use of focus groups (see section 4.1). The structure and composition of these focus groups plus a short description on each focus group is provided in this section.

Section 4.2 presents the findings from the study under three main themes: Cultural influences, Socialisation processes and Power /powerlessness. The chapter concludes with a reflective piece followed by a chapter summary.

4.1 General description of focus groups composition

Table 4 provides a detailed account of the demographic information on participants in the present study. Details provided include type of hospital (regional or county), age category, gender and the focus group each hospital represented and the number of people assigned to each category.

Table 4: Demographic details of participants

Focus Groups	Number of Participants
Hospital 1 Focus Group 1 FG1	8
County Hospital	8
Female	6
Male	2
20-24	5
30-34	1
20-24	2
Hospital 2 Focus Group 2 FG2	4
County Hospital	4
Female	4
20-24	3
30-34	1
Hospital 3 Focus Group 3 FG3	9
County Hospital	8
Female	8
20-24	7
25-29	1
Unassigned gender	1
Hospital 4 Focus Groups 4 & 5 FG4 and FG5	22
Regional Hospital	22
Female	19
Male	2
Unassigned	1
20-24	15
25-29	3
30-34	2
20-24	2
Grand Total	43

Five focus groups were conducted (see Table 5), each hospital had its own specific focus group with the largest hospital necessitating two focus groups (due to larger numbers of students). Four hospitals were involved in the study. The numbers of participants in each focus group varied from 4 in the smallest hospital to 12 in the largest. Each focus group in the study is referred to as FG1 i.e. Hospital 1, FG 2 and so on (See Table 5). Each participant in the study was designated a specific reference, for example P.1 is a reference to a participant

within that specific focus group. Each participant's reference is unique to that participant within that focus group for example P.1 in FG 1 is different from P.1 in FG 2.

Table 5: Hospitals and focus groups

Hospital	1	2	3	4	4
Focus Group	FG 1	FG 2	FG 3	FG 4	FG 5
Participants (P)	P. 8	P. 4	P.9	P.12	P.10

The administration and planning of the focus groups is an important part of the research process. Roberts (1997) comments that the ultimate success or failure of data collection hinges on careful planning and facilitation. Polit and Hungler (1997) suggest that qualitative researchers should strive to collect data in naturalistic and realistic settings. The following section details the preparation and planning involved in preparing for the focus groups.

Focus Group 1

Focus group 1 was held at a small county hospital that had been involved in nursing education for over fifteen years through the provision of clinical placements for nursing students. The focus group was organised to suit the participants at a time they were free from placement. However, one student could not attend. Eight participants attended this focus group. The room was bright and airy and free from distractions. Participants in their demeanour were quiet and not energised in terms of their contribution. It appeared to me that they were not convinced of the importance of their contribution. While they answered questions and conversed the group was not dynamic and I felt that it was difficult to get them to converse in a free uninhibited way. I attributed the lack of energy initially in part to my own facilitation skills as this was the first formal focus group. However, on reflection I believe this was more to do with participants as they appeared to lack energy and were not as engaged or dynamic as some of the other focus groups.

Focus Group 2

Focus group 2 was held in a small county hospital that had been involved in nursing education for over ten years through the provision of clinical placements for nursing students. The focus group was organised to suit the participants at a time they were free from placement. However, one student could not attend. Four participants attended this focus group (all scheduled participants attended). The room was bright and airy and free from distractions. Participants in their demeanour were energetic and positive. Their enthusiasm was palpable; participants described empowerment they knew what it was they kept giving examples of how they felt empowered and why. Participants were emphatic in their views and commitment to nursing they knew what they felt and were confident they could make a difference to care. They spoke about being positive and maintaining that despite the stresses of the environment. They came across as passionate and appeared to enjoy being a nurse. This was a very upbeat and energised focus group. On leaving the group I was enthusiastic about this group and their energy and their love for what they did.

Focus Group 3

Focus group 3 was held in a small county hospital that had been involved in nursing education for over twenty years through the provision of clinical placements for nursing students. The focus group was organised to suit the participants at a time they were free from placement. Eight participants attended this focus group (all scheduled participants attended). The room was bright and airy and free from distractions. Participants in their demeanour were positive and articulate and were keen to contribute to the discussion on empowerment. This group appeared able and willing to discuss empowerment in a very uninhibited way. There was one dominant participant but all other participants did participate. Through facilitation the dominant participant was managed in order not to overshadow the contribution of others. Overall a feeling from the focus group was that although the environment was sometimes difficult this was an assertive group who were able to acknowledge and verbalise their thoughts very well.

Focus Group 4

Focus group 4 was held in a larger regional hospital that had a long history of involvement in nursing education through the provision of clinical placements for nursing students. The focus group was organised to suit the participants at a time they were free from placement. Ten participants attended this focus group (one participant scheduled did not attend). This group had very different characteristics than the others so far. They appeared to lack confidence and lack support. Some participants were nervous and needed coaxing to contribute, while others were more vocal. There was a feeling that this group were disenfranchised - they were a group apart from others within the organisation. There were positive contributions but the overall feeling on leaving this focus group was one of sadness.

Focus Group 5 (same hospital as Focus Group 4)

Twelve participants attended this focus group. I felt they were under pressure and found it difficult to start the discussion. However despite this they were articulate and clear in wanting to contribute to a discussion on empowerment. Some participants in this group were quite positive and assertive but overall an impression of how it helped this group to talk and share their experiences. This was something they said to me on leaving, I felt they thought and verbalised aspects of nursing they had not had an opportunity to do before now.

4.2 Presentation of findings

This section outlines how the findings of the present study are presented under the identified themes that emerged from the focus groups: cultural influences, socialisation process and power and powerlessness.

Theme 1 cultural influences are presented in section 4.3. The sub-themes of organisational/hospital culture (section 4.3.1) and ward/unit culture (section 4.3.2) divide this theme into two sub-themes. Each sub-theme is presented using headings for ease of navigation. Focus group 2 is discussed in section 4.3.3 as a

‘deviant case’ as the attributes and values of this focus group were identified as different from the others. This section concludes with a brief summary (section 4.3.4).

Section 4.4 presents the findings of theme 2: socialisation process. Following a brief introduction to the concept of socialisation in nursing socialisation is presented using sub-themes that describe three phases of socialisation as experienced by participants in the study: Phase 1: assimilation phase (section 4.4.1), Phase 2: appeasement phase (section 4.4.2) and Phase 3: chameleon phase (section 4.4.3) together with key literature that informed part of the data analysis process (section 3.5). This section concludes with a summary of the findings on socialisation (section 4.4.4).

The final theme of power /powerlessness is presented in section 4.5. The theme of power / powerlessness is presented using the identified sub-themes: status quo (section 4.5.1), drowning in disempowerment (section 4.5.2), vulnerability of nursing students (section 4.5.3) fear of failure (section 4.5.4) and economic climate (section 4.5.5). Focus group 2 is discussed separately (section 4.5.6) as the findings were different to that of the other focus groups in relation to power. This section concludes with a summary of the theme of power (section 4.5.7) and powerlessness followed by a reflective section titled researcher’s voice (section 4.6). The final section (4.7) of this chapter provides an overall chapter summary.

4.3 Theme 1: Cultural influences

The importance of culture and empowerment is presented in section 1.7. However, how culture is perceived and experienced is unique to the individual and for the purpose of clarity is described at this juncture. Culture, according to O’Donnell and Boyle (2008) is concerned with beliefs, meanings, values, language, norms and also about the way we do things here. In this study through discussions in focus groups participants discussed their attitudes, assumptions and values in relation to culture. Bratton et al. (2007) highlight that within each culture sub cultures may exist this was reflected in ward and unit cultures in this

study. Ward/unit cultures, within the context of this study are micro cultures that may or may not be reflected within the organisational culture. Culture was a major influence of participants' empowerment and disempowerment in this study. Participants knew and had experienced different cultures as they reflected on their empowerment. Empowerment for participants was contingent on culture.

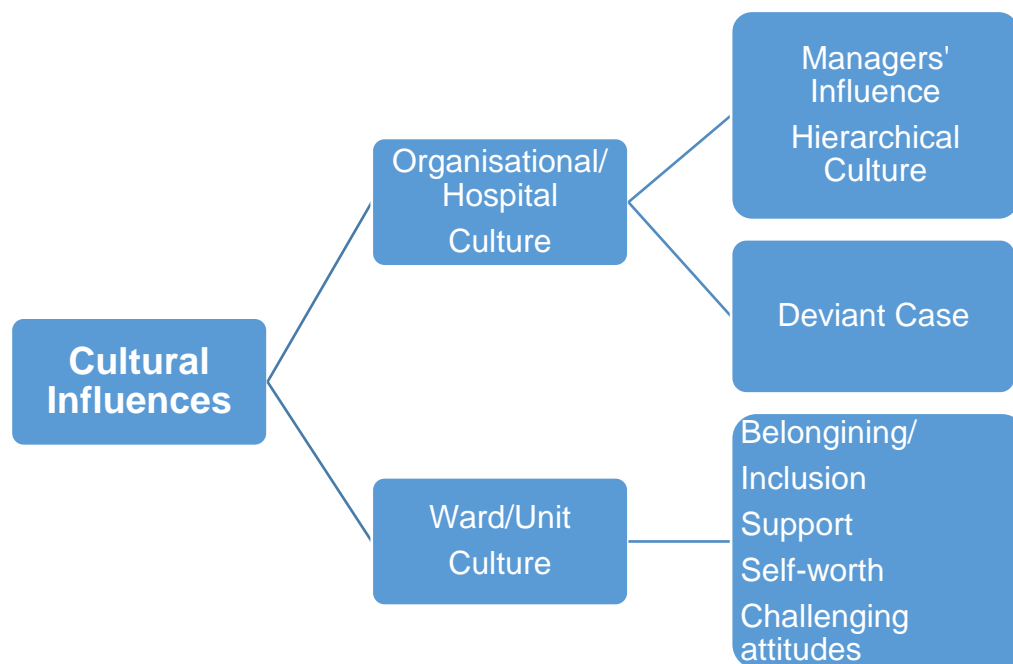


Figure 2: Theme 1: Cultural influences

As can be seen in Figure 2, the theme of cultural influences was divided into two sub-themes, namely organisational/hospital culture; and ward/unit culture. Within both of these sub-themes participants' descriptions of empowerment as it relates to culture are presented, firstly organisational/hospital culture: where the findings are presented under the headings: managers' influence and hierarchical culture. Secondly ward/unit culture: under the headings belonging and inclusion, support, self-worth and challenging attitudes. A deviant case is also presented within this section.

4.3.1 Organisational/hospital Culture

The participants in this study demonstrated an awareness of the organisational culture in addition to awareness of the ward culture in which they undertook their clinical placement. The HSE as an organisation is described in terms of its history and formation section 1.2. This is relevant to this study in that all of the hospitals involved in the study shared common governance and structures. Many participants had experienced clinical placement in at least two different hospitals by the time they reached final year placement and so were able to identify differences in organisations in addition to wards/units. The findings from this study under the sub-theme of organisational culture are presented using the following headings: managers' influence and hierarchical culture.

Managers' Influence

The following quotation demonstrates the participants' awareness of the managers' contribution to culture:

FG5 P.2: "I think they (the managers) can bring either a sense of calm or mania to the equation and a lot of it filters down to the ward level. Here, there is a really good supportive culture."

Participants in the study identified how the culture among senior hospital management was a major contributory factor to their (the participants') sense of empowerment, as reported by FG5 P.1.:

FG5 P.1: "The ward I am on now there is a really good manager and structure and that filters down and so there is a very supportive culture."

Ward managers impacted participants' empowerment in this study, as is seen in the quotations from participants. Experiences of the clinical learning environment in this study varied, and many of the participants had different experiences. This is important as all participants were deliberately allocated on their internship to the clinical learning environment for a specific learning experience. Conversely, not all participants had such empowering experiences, with some describing a more

oppressive and hierarchical structure within their hospital setting that appeared to impact their learning and empowerment. Some of these experiences were shaped by the managerial approach to the nursing student, as the quotation FG3 P.2.demonstrates:

FG3 P.2: *"I remember sitting waiting for a telephone call in relation to a patient I was looking after – a Senior Nurse Manager was coming down the corridor and she just stopped and said 'What are doing sitting down? Do you realise how busy this hospital is?'"*

Despite the many changes in health care, the perception of the "busy nurse" on the move still exists, where movement and being busy are equated with being "a good nurse", as is evidenced in the quotation given by FG3 P.2. It was also clear that the historical, hierarchical structures continue to exist within the hospital settings. These findings concur with many other Irish studies support this contention, such as Begley & White (2003) and Timmins & McCabe (2005); in which it is noted that nursing students lack the empowerment and confidence to challenge the *status quo*, while Levett-Jones and Lathlean (2009b) also noted that nursing students were not assertive and were found to engage in conforming behaviours.

Hierarchical Culture

Despite the many changes in education and programme development, the culture in nursing is often viewed as oppressive and hierarchical (Kuokkanen & Leino-Kilpi, 2000; Peltomaa et al., 2013). One participant explained that the culture is such that being assertive is viewed negatively and people get a reputation if they are assertive:

FG3 P. 5: *"If you stand up for yourself (I don't mean be cheeky) I'm sure they would pass it around about you. It can go viral."*

Participants were aware that they were not in a position to challenge authority. All present in this focus group were supportive in terms of body language nodding and affirming when P. 5 made this comment. Being assertive or disagreeing with those in authority was not considered by this participant as an option:

FG3 P.3: *“A lot of them (nurse managers) are so senior to us it is best not to say anything to them.”*

It appears that participants in this study did not appear confident with management in this instance and lacked the empowerment to deal with managers and the hierarchical power structures:

FG4 P.1: *“The clinical nursing manager would have to be more empowered than a newly qualified staff nurse. There are just certain situations where your status has an impact on your empowerment.”*

In addition it sometimes appeared that empowerment and position/hierarchy were confused for the participants. However, it is acknowledged by many (Ryles, 1999; Manjilovich, 2007; Bradbury-Jones et al., 2008) that the relationship between power and empowerment is complex. Participants believed that the lack of empowerment was associated with their position and therefore would be a transitory phase:

FG3 P.7: *“You let them have the power over you until you can stand up for yourself a bit more as a staff nurse but as a student you just want to get through.”*

However, this hierarchical culture appears from the literature to be self-perpetuating and therefore potentially would continue once qualified (Hollins-Martin & Bull, 2010). This culture appeared to perpetuate as consultants and other members of the multidisciplinary team also ‘picked up the habit’ according to FG1 P.1:

FG1 P.1: *“Sometimes the consultant won’t ask the student about a patient when the student is looking after that patient. Then the intern picks up that habit and before you know it nobody wants to listen to what the student is saying.”*

Nursing students in some of the hospitals articulated this, describing that they felt diminished by their lowly status within the hospital hierarchy, thus demonstrating their awareness of the hierarchical culture and feeling powerless within the system:

FG3 P.17: *"I think they think that (the) student nurse is just the general dog's body. If the carers don't do it, it's thenurses; if the doctors don't do it it's the nurses; if the cleaners don't do it it's the nurses..."*

All participants in this focus group (FG3) nodded their heads and their body language indicated that they strongly agreed with this one participant and her summative views. The participants felt demoralised by these remarks and described feelings as though they were 'at the bottom of the ladder'.

4.3.2 Ward/unit culture

Each hospital consists of micro cultures which are comprised of units and wards. Therefore, despite the influences of the organisation, individual micro cultures comprising wards/units are also significant and potentially different influences. Laschinger et al. (2009), in their study of ward/unit leadership on empowerment, highlighted the importance of empowering leadership on individual nurse outcomes, resulting in a more committed workforce. The sub- theme of ward/unit culture is described using the following headings: belonging and inclusion, support from preceptors, self-worth and challenging attitudes:

Belonging and inclusion

"Feeling needed" was threaded through many of the themes in this study, and this may be related to it being a fundamental part of being a nurse and of being a nursing student. Being needed was described by participants in many different ways. For example, the participants in this study demonstrated a strong desire to provide optimum care for their patients: they explained that when wards were short-staffed, it was their opportunity to demonstrate what they could do and ultimately be rewarded through inclusion and staff needing and relying on them:

FG2 P.1: *"It's actually better when there's a nurse out sick because I've my own patients; the Sister is helping out ...it's really nice."*

Participants said they enjoyed being able to "*do something*" and that practising their skills gave them independence and confidence. Therefore, they were

relieved to be of assistance to their preceptors in a practical way. Participants in this study understood that in exchange for their labour they gained experience and competence. The majority recognised that they felt *needed*, and this was something that made them feel empowered as, illustrated in the following comments:

FG4 P.5: *“They’re grateful you are there – they say that because you are taking a bay of patients that would be an extra caseload for them if you were not there.”*

Participants liked to be part of the ward, recognising the ward benefits by receiving additional help, and felt *“needed”* when they had contributed to the workload. As one participant described:

FG3 P.1: *“It gives you a little high.”*

This made the participants feel worthwhile and valued. One participant described how being thanked at the end of a day made a difference to how she felt:

FG3 P.3: *“Even if it’s thanking you at the end of a day, you feel so much better.”*

Being needed and being appreciated by the qualified ward staff impacted participants and how they felt on the ward. One participant described how being busy on the ward actually helped her to feel she was contributing, and therefore appreciated, for her work contribution:

FG4 P.4: *“For me it was the days we were short staffed that I felt that I was more treated like a colleague more so than a student.”*

In this description, feeling like a colleague was making a reference to feeling worthwhile and needed, but also implied that sometimes participants felt like a burden to staff, which is discussed in the following section. It is also interesting to note that feeling like a *“colleague”* in this description is better than feeling like a *“student”*. This is further evidenced by the participants in the present study who perceived themselves as being at the lower end of the nursing hierarchy.

Participants in some focus groups felt supported in their learning and felt that as a result that they grew in confidence. Confidence was a factor in promoting their empowerment:

FG2 P.4: *“I’m more confident now and I’m really supported on the ward. They are really good. You thrive off it. When you see you are making a difference there is actually some progress.”*

When participants felt supported in their practice, they gained in confidence and it was a positive experience for the participants learning in a supported way. Preceptors have a big influence on the clinical learning environment and this was reported as being very important to the participants. Participant’s believed that the preceptor’s commitment to teaching and supporting them demonstrated their interest in nursing students’ learning. This, in turn, provided the participants with the confidence they needed to practice in an empowered way. Participant’s valued and appreciated when their voice was listened to in the following way:

FG2 P.3: *“Whether they can do anything for you or not they will try. If they can they will but if they can do nothing for you they will listen and tell you why not.”*

Participants explained that they needed the affirmation of their role and themselves by the preceptor in order feel their own self-worth and grow in confidence. They also demonstrated, in the quotations above, that they did not have unrealistic expectations of their preceptors: merely demonstrating an interest in their learning and listening to the nursing students was often enough. When participants were included onto the nursing team by colleagues and preceptors their participation and ultimately their empowerment, increased:

FG1 P.1: *“Who you are working with for the day (preceptor) means you can have a sense of security you’re involved, you know what’s going on, you get the full picture...”*

FG1 P.3: *“your part of the ward they know you go on breaks together, you can build on that relationship; everyone is working towards the same goal...”*

Being included as a valued member of the team was important to the students and the participants recognised how this contributed to their learning. Being included on the team involved simple everyday tasks, but these resonated with the students and left an impression of inclusion and being a part of the team, as the following participant explains:

FG5 P.3: *“Now you are eating with staff on breaks and everything is much more relaxed chatting, about normal things but this makes me feel so much more relaxed.”*

FG3 P.8: *“It is so nice working here: the nurses are really friendly and helpful, the doctors know you on first name terms, they ask you how your day is, they ask you to accompany them on medical rounds...”*

The findings of the present study concur with seminal and contemporary research when it noted the challenge for nursing students was being both learner and worker (Melia, 1987; Levett-Jones & Lathlean, 2008; Newton et al., 2009). Many participants in the present study described how just as they begin to feel part of the team just before leaving and describe the challenges of starting over again in a new placement:

FG5 P.3: *“You get to know all the staff and you become part of everything and then you have to change to a different ward and start from scratch again.”*

When the participants felt part of the team they valued how it made them feel and could compare the feeling of being part of the team to other experiences of when they were excluded. This made teamwork central to a supportive empowering environment in the following nursing student's view:

FG2 P.14: *“I felt in the other hospital, everyone is out for themselves, whereas here it's definitely a team thing.”*

These findings support Levett-Jones and Lathlean's (2008) and Newton et al. (2009) studies that noted how nursing students feel empowered and enabled to capitalise on learning opportunities once they feel they are secure and belong in the clinical learning environment. It was clear that participants were conscious of working and learning simultaneously, and were aware that they are transient

members of a team. They also demonstrated an appreciation that they need to become part of the team in order to succeed during clinical placement. Participants felt that, once qualified, they would belong and be accepted as fully-fledged team members:

FG2 P.4: *“When you are qualified it will be different; you will be included as part of the team.”*

The participants felt vulnerable as they were not part of the workforce and were self-conscious of their struggle to be accepted in the team. The participants in the present study were cognisant of the importance of being part of the team and a sense of belonging. It was significant to note that Levett-Jones and Lathlean (2008), in their joint study of 18 participants from the UK and Australia, found that the concept of “belonging” was a prerequisite for learning while on clinical placement. Belonging to a team, and being needed, empowered nursing students in Levett-Jones and Lathlean’s (2008) study to avail of further learning opportunities. When participants did not feel part of the team, and were excluded, they felt diminished and their confidence was low and subsequently felt disempowered, as is reflected in the following:

FG3 P.4: *“Sometimes you feel useless, absolutely useless; you just constantly apologising for yourself during the day.”*

Interestingly, Baumeister et al. (2002) found that when nursing students did not feel as though they belonged they suffered a short-term cognitive impairment that impeded their learning due to reduced intelligent thought. While James and Chapman (2009) in an Australian study of nursing students’ experiences on their first clinical placement, found that when the nursing students perceived that they were a burden their intention to stay on the course was affected:

FG 5 P. 4 *“ I don’t know how to describe it (not being included) for the first few weeks I was here, I was dreading coming in It was so bad for a while. ... I didn’t enjoy the way nursing was run...the team nursing. I was always going around in circles”*

Being facilitated, therefore, to join the nursing team, albeit for a short time, can have an impact on learning (Newton et al. (2009) and consequently on empowerment, as seen in this study. Inclusion clearly influenced participants' empowerment in the present study, and while participants encountered both being included and excluded from the team, all had experienced being part of the team on occasions.

Support from preceptors

Much has been written in the literature on the importance of the role of preceptors (Callaghan et al., 2009) and the need for a supportive clinical environment in order for preceptors to make a valid assessment of their students' clinical placement learning (Butler et al. 2011). Support for nursing students is provided by the preceptor primarily within the clinical learning environment. Participants depended on their preceptor for the support they required:

FG1 P.8: "It all depends on your preceptor: you have a sense of security and then there are other days and you are working with someone different, you're completely out of the loop."

When participants were asked for an example of what made them feel empowered, one participant explained how important trust is in the relationship with preceptor:

FG5 P.6: "It's the trust and the rapport between you and your staff nurse (preceptor); it means when it's there you'll be treated the very same as each other."

It is therefore necessary that nursing students experience an environment of trust and respect in order for them to feel empowered. Chang et al. (2015) note that many preceptors found preceptorship training did not prepare them for the challenges and stresses of the role. Some participants in this study however, were encouraged and enthused by the preceptorship support and described how the role of their preceptors directly impacted on their empowerment in the following way.

In the following transcript the dynamic of conversation is obvious when the participants discuss preceptorship support.

FG 4 P. 10: *"It makes a big difference when a nurse asks you if you have any questions, or did you get to see this or that. It makes you feel they want you to learn and they are ensuring you meet your learning outcomes, rather than just being there as an extra helping hand."*

P. 26: *Sometimes you feel that you're not really learning.*

P 25: *Yeah, you're doing the best that you can but you know you're not.*

P. 26: *And the staff are always saying "I didn't get to teach you anything today" or "I didn't get to explain this to you but we'll go over it" and they are trying to find five minutes to tell you about "Why we're doing this?" and then you're running around wondering "Have I done everything for people?" .*

All Participants: *Yeah.*

Positive support from preceptors was hugely important to the participants in this study. While the primary focus for the preceptor is on primarily on safe patient care, the preceptor also has an educational and supervisory role, and is responsible for ensuring that the nursing student delivers safe and proficient care. The role of the preceptor is complex and challenging and well recognised in the literature (Gallagher et al., 2012). Participants valued the support of their preceptors and found them to be a great asset in the clinical learning environment:

FG5 P.6: *"I feel really supported by my preceptor when she asks me about my learning outcomes. I get so much more out of this type of ward when your preceptor is so supportive"*

FG 1 P.14: *"The empowered ones (staff nurses) are the ones you want to work with."*

The participant describes how being with a preceptor who is empowered makes her feel fulfilled. Preceptors in recent nursing literature have been found to be stressed and burdened with their dual role of nurse and student educator and

assessor (McCarthy & Murphy, 2008; Chang et al., 2015). Preceptorship was described as a positive experience when participants received feedback, felt part of the team, and felt needed. This made participants feel confident.

Self-worth

Self-esteem is an important predictor of human behaviour and determines qualities such as empathy, and the ability to form sound interpersonal relationships (Randle, 2003b). The preceptor was a key influence on the ward culture in the present study as identified in communication and feedback. Feedback was an important contributor to the nursing students' empowerment and feeling of self-worth, and was valued by the participants in the present study. Feedback affirms positive behaviours and it is well recognised in nursing literature for its important influence on teaching and learning (Myrick et al., 2010; McCarthy & Murphy, 2010). Developing and nurturing self-esteem therefore are important determinants for nursing students to experience:

FG2 P.6: *"When you do get feedback whoever it's from (patient or staff) it's great."*

The participants found that constructive feedback helped them to engage in learning and empower them to improve their practice:

FG1 P.2: *"Preceptors giving feedback in a constructive way is really helpful. Some preceptors could give constructive feedback without putting you down in a really positive way. That really empowered me, but I could see that in her relationships with other staff too she really was empowered."*

FG3 P.2: *"I'm more confident and I'm really supported on the ward. They are really good to me."*

The following participant described how she felt supported to learn in the clinical learning environment when preceptors helped with encouragement:

FG4 P.4: *"It not even what they (preceptor) say – it's the smile or a wink. It's the little things that your preceptor does that picks you up on a bad day."*

Participants were aware and discerning in recognising the supportive culture when they experienced it in the clinical learning environment:

FG3 P.4: *"I think it has to do with the culture on each ward and the relationship between the qualified staff and the students."*

The relationship of the preceptor with the nursing student was very important to the participants in reinforcing self-worth and self-esteem and was demonstrated through the time they (preceptors) invested in the nursing students. Time was spent in various ways both through the official process of clinical assessment and also verbally, while working with the nursing students. Participants in this study also experienced the benefits of supportive relationships and explained how it improved their desire to reach their full potential:

FG4 P.23: *"If you are told 'well done you did that well but you need to work on that' it makes you feel so good."*

The barriers to the provision of constructive feedback are well documented in the literature (Spouse, 2000; Butler et al., 2011). There are many reasons why preceptors do not give meaningful feedback to undergraduate nursing students. The demands of the clinical area and lack of time are all factors that contribute to the challenges for the preceptors (Bradshaw et al., 2012).

Challenging attitudes

In contrast with being needed, participants compared days when they felt *"in the way"* and a *"nuisance"*. These were days when they were constantly apologising for their presence and feeling that they should not ask questions. Unfortunately, not all the participants felt needed and of assistance throughout their clinical placements, with many (participants in FG 1, 3, 4, and 5) reporting that they felt unwanted and a burden to staff on occasions. Some wards felt unable to accept a nursing student on clinical placement, as this participant described:

FG3 P.2: "It was said that they (ward staff) didn't want students and a student would be too much of a burden to them."

This feeling of being a burden was expressed in a variety of ways across many of the themes. Expressed simply as above, it appears just to be one ward; however it was also apparent in how the participants described their learning opportunities on the wards, as echoed below:

FG2 P.4: "If I had something to ask I just couldn't I would just feel as if I would be wasting their time."

This made their clinical placement difficult and they found that it diminished their experiences, as:

FG1 P.1: "We all hate it when a staff nurse says 'can I borrow your student?' and when they do not call you by your name. You are just seen as a pair of hands that is probably the worst feeling of disempowerment you can have."

The participant explained that doing the basic nursing care was being 'treated as an extra pair of hands'. This revealed an interesting insight within that specific nursing culture into how doing the essential care was regarded. In addition this participant described how dehumanised she felt that her contribution was not of worth or held in high esteem. The findings of the present study support research from Bradbury-Jones et al. (2011) who found that nursing students from Year 1 to Year 3 reported "being valued" as a prominent theme. While, belittling and poor treatment of nursing students eroded their self-esteem and ensured that they worked hard at not being the subject of further demoralisation and hurtful commentary (Luparell, 2011). One participant described the challenges of the clinical environment and how she fitted into it in the following way:

FG5 P.3: "It is basically sink or swim. You are in charge of a bay of patients (6) and you have to look after them."

This quotation describes the challenges of becoming a nurse, but also of pursuing nursing as a career in the face of adversity. This was a poignant moment in the

focus group. There was widespread consensus amongst the participants that this was the case for many of them. All participants were in agreement and their facial expressions and intent that was felt when this was voiced was palpable in this focus group. Many of the participants in the study accepted the challenges of socialisation into the environment stoically and strove to be the best they could within this environment. Two Australian studies conducted by McDonald et al. (2012 & 2016) support the contention of work place adversity and incivility and the potential of resilience to help staff and students to cope with such situations:

FG1 P.7: *“You can see the benefits of when you’re empowered and the difference it makes; and when you’re disempowered you see the damage it does. So you have an understanding of what it takes to empower other nursing students...simple things like referring to them by name and not calling them ‘student’. Because, we all hate being referred to as ‘the student’.*

However, some participants expressed disempowerment, referring to the damage it causes, and being aware of the benefits of empowerment through their experience of disempowerment. The palpable low self-esteem and disillusionment amongst participants was further evidence of the need for empowerment in the clinical environment, and demonstrated evidence of disempowerment. This was verified and endorsed through observation of the facilitator of the facial expressions and the generalised consensus in the focus groups when participants described disempowerment. The tones and voices on the audio tapes also supported their descriptions of disempowerment. This triangulation of data in qualitative studies is discussed in section 3.13. O’ Mara et al. (2014) noted that the experience of the clinical learning environment for some students was emotional and fear-inducing. Other nursing students in the present study described an openly hostile environment, where staff openly disagreed and where the nursing students struggled to belong:

FG4 P.15: *“I feel sometimes like everyone is attacking everyone and it gets so tiring. You need a thick skin – I take it personally sometimes. Everyone is at each other, wanting to blame each other for something...”*

Furthermore, O’ Mara et al. (2014) describes the challenges within the clinical learning environment as limiting the learning opportunities for nursing students. In

the present study, no participant directly reported feeling bullied, but the environment was described in a negative and adversarial way as recorded in the following quote:

FG3 P.9: *"It's hard to be a nurse these days I love nursing and I love being a nurse: I just wish the conditions for being a nurse were a bit easier."*

Price (2009) in his meta-study on socialisation in nursing found that it was recognised in several studies that nursing students did not want to become "uncaring" or "hardened" (Mackintosh, 2006; Price, 2009). Participants in the study found it difficult to reconcile their desire to provide nursing care with the challenges presented in the clinical environment. FG3 P.9 described the challenges she experienced delivering care to her optimum ability within this environment, wanting to do a good job but finding it difficult. Participants were aware of how difficult the environment was and the impact of continuously striving to be empowered in the care they deliver is described in the following quotation:

FG2 P.3: *"A lot of nurses say 'I was like you at the start and that eventually wears out... I was full of optimism at the start... but you will wither'"*

Newton et al. (2009) in an Australian study of nursing students suggests that students need supportive and positive placements that demonstrate openness in order to encourage novice nursing students to become part of the profession. Findings in the present study reflect this conflict of the participants' ideals versus the reality of the learning environment, as they try to find a way to "fit into" the clinical environment. The importance of a role model and preceptor that is empowering and supportive is paramount for nursing students to cope in this environment:

FG3 P.9: *"You look at the off duty and you see who you are working with tomorrow, and it just puts you off coming in because you know the night before exactly what your day is going to be like..."*

Participants were aware of challenging personalities of preceptors and accepted that they would have a difficult time as a result. Duchscher and Cowin (2004)

argued that resources and effort should be used to ensure that the clinical learning environment is more supportive and less combative. This is evident in this comment from a participant:

FG4 P.6: "When someone (staff nurse) makes little of you and shouts at you in front of the patient, it puts you down and puts a damper on the whole day."

Incivility in nursing has long since been reported in nursing literature. Findings of the present study are supported by International literature that found undergraduate nursing students are likely to experience negative behaviours and incivility in the clinical learning environment Hunter, (2005); Lash et al. (2006); Gillen et al., (2009); Roberts et al. (2009) and Laschinger et al. (2010b).

4.3.3 Focus group 2: A deviant case

Focus group 2 experience of culture appeared different than that of the other focus groups (focus group 1, 3, 4 and 5). Participants (in all focus groups) conducted in this study described positive experiences of empowerment while some participants described the "damage" (focus group 1) of disempowerment (section 4.3.2). Participants were forthright and open when discussing empowerment or the lack of it in the clinical area, and acknowledged its presence and importance. Participants experienced both empowerment and disempowerment in the present study, which is an important and relevant finding as it highlights that empowerment, is transient and can change.

In focus group 2, participants articulated a predominantly different experience. In this focus group, the participants described their empowerment in clinical placements in a very positive way. Participants within this focus group reported being accepted and welcomed as nursing students and being part of the team, which contributed to their sense of value. This is replicated in other focus groups, but was more pronounced and unanimous in focus group 2:

FG2 P.4: "It's real team orientated. It's not split like in other hospitals you have the nurses and then the doctors here it's just a lot more teamwork."

FG2 P.15: *“Yea, I think that the hospital culture is important in spurring on your empowerment and making you feel valued – it is purely a cultural thing.”*

Elements of positive teamwork were found throughout all the focus groups but they were combined with other negative experiences of teamwork. In focus group 2, participants had experienced empowered practitioners during their placements and they had a very good understanding of what it meant to practice in this environment:

FG2 P.3: *“I spoke to another nurse who had worked abroad and in different hospitals in Ireland and she said she hated it there as there was no team. When she came here (to this hospital) she noticed the difference and I totally agree.”*

Participants in focus group 2 articulated the impact that their empowerment and their commitment had on patient care in the following way. Participants were clear and unambiguous in attesting to the value of empowerment on patient care:

FG2 P.3: *“You just stay and do the work to make sure the patient does not miss out. You make sure that they are still getting the care.”*

In this focus group participants described how the staff were so empowered that they worked through their breaks in order to provide patients with the care they needed. The priority for staff was the patient and the culture was that the patient was the focus:

FG2 P.2: *“We haven’t taken evening breaks in ages you just stay back to make sure the patients don’t miss out.”*

This confirms the importance of empowerment to patient care and supports other studies that have linked empowerment to improvements in patient care in the nursing literature (see section 1.7.1 & section 2.5.4). It has been highlighted that there were some differences between the focus groups despite shared governance by the HSE. What contributed to the difference between focus group 2 and the other focus groups may have been attributed to the fact that there were fewer students in focus group 2. This may have contributed to the lack of

dissention in the group or a more group like consensus due to smaller numbers (see Table 5). Another difference in focus group 2 was that management's approach to the participants was empathetic and supportive:

FG2 P.7: "I was asked to swap my duty the other day and when I said I could one of the managers said 'that's great you really got us out of a hole thanks a million.'" And I thought she didn't have to come back and say that but it's the little things that really make you feel like you can help out."

Focus group 2 demonstrated a different experience of management describing a less hierarchical approach than in other focus groups and it also appeared to be more people focused. This is demonstrated in FG2 P7 by the Nurse Manager coming back to express her appreciation to the nursing student for facilitating a swap of duty. It also appeared that an ethos of respect was apparent towards the nursing students. It is interesting to note that in focus group 2 the participants described how the Director of Nursing (chief nurse) would come to the ward and compliment them on a job well done:

FG2 P.12: "I have met the director of nursing a few times: she complimented us, saying "Girls (nursing students) you are doing great. I have heard great things about you all'. It really does help when they (senior management) take the time to talk to us so positively..."

The fact that management's influence was mentioned in such a positive way (was not reflected in any of the other focus groups) may have contributed to the participants' more pronounced sense of empowerment within focus group 2.

Interestingly, Begley (2002), in a study on Irish student midwives, found that the nursing students did not perceive the Director of Nursing as having an influence on them. In the present study, the Director of Nursing appeared to have a positive effect on the organisational culture, and the participants (focus group 2) viewed her contribution as positive to their empowerment. When participants in FG 2 were met by the Director of Nursing, they perceived it as an important and significant event. Furthermore, it appeared to positively impact on their perception of the hospital service. Traditions and practices can contribute to an

organisation's culture in a positive or negative way. Participants described what it felt like to work in an organisation where the culture was empowering:

FG2 P.12: *"You are called by your name and not just 'nurse'. Everyone looks out for everyone."*

When participants described this positive type of culture, they explained that the organisation had an empowering and inclusive effect. Participants described how they were included with the other staff giving them a feeling of making a difference and being part of the hospital and ward/unit:

FG2 P.3: *"Here it is like a family even though it is a big hospital. Everyone looks out for everyone from the porter to the doctors."*

A feeling of being included within the hospital appeared to give a sense of security and protection and concurs with the literature, supporting the assertion that inclusion and feeling part of an organisation facilitate feelings of security, and is therefore a trigger towards motivation, growth and learning (Levett-Jones & Lathelean, 2008; Koontz et al., 2010). The following participant described the empowering organisational culture in the following way:

FG2 P.9: *"'You're only a student' – you don't ever hear that: here you are always listened to."*

The participant quoted above appreciated that she was always listened to and that her role as learner was not diminished. This again reinforces the respect provided to all who work at providing patient care. It is interesting that she does not convey an expectation of being valued as a learner, but rather she shows an appreciation of it. It is possible that this is because of the historical and cultural legacy (see section 1.2) of nursing at a national or international level, as discussed in previous chapters. This is further discussed in section 5.1.2.

4.3.4 Concluding points on the theme of cultural influences

Culture is identified as a dominant theme in this study. Culture and the ways things are done within an organisation and on a ward or unit impacted nursing

students in terms of their empowerment or disempowerment. A variety of experiences were described by participants in the study: some experienced an empowering culture, while others described feeling like a burden. Many participants were aware of different cultures. It was clear however that supportive learning environments, that included and made participants feel part of the ward/unit impacted participants empowerment. Support to the participants was provided primarily by their preceptor who influenced their self-worth and their empowerment. Challenging behaviours and attitudes also exist and can cause disempowerment for nursing students on clinical placement. Negativity, lack of encouragement, interest and time contribute to these feelings of disempowerment. Focus group 2 (deviant case), participants described a predominantly empowered experience while on clinical placement. This was described as being influenced both at a management and ward level (see section 4.3.3). Most importantly participants described a supportive culture impacted their empowerment and also how being empowered consequently impacted the care they provided the patients. They described how being included and feeling needed, and developing confidence were essential to the development of their empowerment. Both the patient and the participants in focus group 2 appeared to benefit from the supportive culture.

4.4 Theme 2: Socialisation process

The socialisation process for participants in this study was an important factor in their empowerment and disempowerment. Most of the literature on socialisation of nurses into the profession dates back to the 1950s and 1960s, when undergraduate nursing students were educated through the apprenticeship model (Stockhausen, 2005). The socialisation of nursing students into the clinical area is a process that begins on entry into nursing and continues throughout the nurses' professional life (Dinmohammadi et al., 2013). Both Davis (1975) and Melia (1987) considered socialisation. Davis' Theory (1975) of Doctrinal Conversion described how nursing students internalise the values, expectations and norms of the profession. Melia (1987) described how nursing students fit into ward environment by doing the work and playing by the rules. Historically, society and individuals had different expectations on entry to the profession of nursing, in

comparison to today's nursing students (see, section 1.2). However, it is important to acknowledge the history of nursing and specifically nursing education as it continues to impact the present. Being socialised into nursing and learning to fit into a ward were challenges expressed by the participants in the present study. Being socialised into nursing is about belonging and the desire to fit in (Levett-Jones & Lathlean, 2008). The desire to fit in and belong is acknowledged as being a basic human need by Maslow (1954) in his seminal work. Nursing students strive to fit into the profession of nursing in a process known as socialisation. Three phases of socialisation are described as participants experienced them in the following section (see Figure 3): Phase 1: Assimilation Phase was associated with settling into the ward/unit. Phase 2: Appeasement Phase refers to a strategy described by the participants in striving to please and appease preceptors. Phase 3 refers to the Chameleon Phase that involved changing and moulding to become more like their preceptors in order to gain full acceptance into the nursing profession Phase 4: Acceptance Phase is not discussed in the findings as participants had not reached this stage during the study.

4.4.1 Phase 1: Assimilation phase of socialisation

The descriptions of the socialisation process described in this study are organised and presented in this section as occurring in three phases. In this study the socialisation process was described by participants as a process that involved changing and moulding to become more like their preceptors in order to gain acceptance. Three distinct phases were outlined from the data transcripts following analysis, the fourth or final phase which would be acceptance is not presented or discussed as it was not experienced by participants.

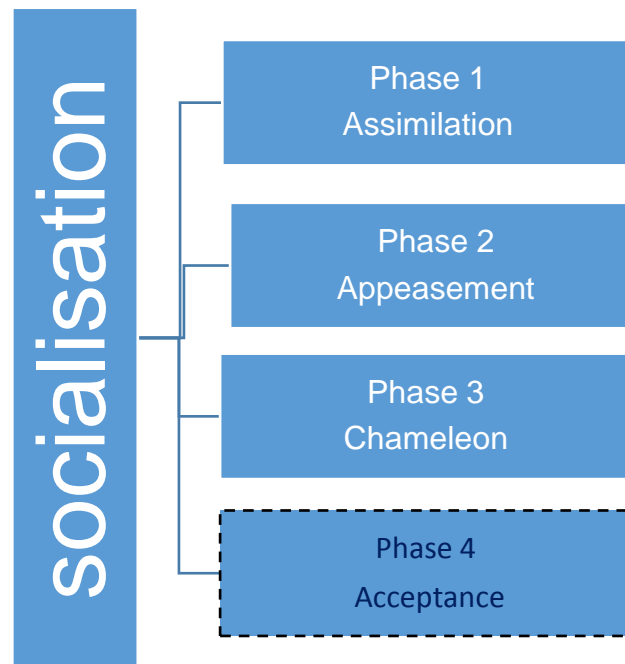


Figure 3: Theme 2: Socialisation process

Nursing students who participated in this study rotated clinical placements several times over their programme (see section 1.2.2). During the internship period (i.e. 36-week final year placement), the participants were allocated to a specific hospital for the duration, rotating three times to different wards within that hospital. Being assimilated into the ward/unit and settling in was a process familiar to the participants in this study. However, the majority approached the period of settling into a new clinical placement in a similar and deliberate fashion. When starting a new placement, FG3 P.7 described how they behaved in an apologetic manner by expressing fear of getting in the way and of being a nuisance to the qualified staff:

FG3 P.7: *"I'm starting in a new placement today and the minute I go onto the ward its right okay you can't annoy anyone."*

Participants described the process of socialisation to the clinical placement area as being challenging as demonstrated by FG3 P.7, who described trying not to "annoy anyone". MacIntosh (2003) contends that the socialisation of nurses is a career-long process that is greatly influenced by those with whom one works in practice. Nurses work closely with each other and depend on each other throughout their working day in a unique way. In order to do one's job as a nurse it is essential to have colleagues one can call on for advice or practical help. Perhaps it is for this reason that the socialisation process is continuous and

influenced by those we work closely with (preceptors in this case). Because participants in this study were in their final year they were perhaps tiring of constantly being new and having to work at being new and striving to be accepted:

FG3 P.7: *"It's really exhausting always being the new one."*

FG3 P11: *"I know you can't be assigned the same preceptor all the time but it would be nice to work with the same people every day."*

Cope et al. (2000), in an early study of Scottish nursing students, notes that being accepted and joining in the nursing profession is complex. Findings in this study concur with these findings today, that the socialisation process is complex and challenging for most nursing students. Participants acknowledged that being assimilated into the clinical practice area and getting to know the team and the personalities on over a relatively short period was stressful for all the participants. One participant described it in the following way:

FG4 P.1: *"It takes a good month to get to know the staff and for them to get to know you: the longer you are there the easier it gets, until you start a new ward and it starts again."*

This was a theme replicated in previous research by Cope et al. (2000). Cope et al., (2000) in a Scottish study of nursing students, found that nursing students experienced feelings of isolation, which were attributed to them not knowing the staff, and also due to their lack of professional competency. Bradbury-Jones et al. (2011) found that strategies to help nursing students fit in were; being treated with respect and being called by one's name. Participants in the present study described being included by qualified staff such as at break time, as important:

FG3 P.11: *"Here it's easier: initially I was like, 'is it okay for me to go to break with you?' And the staff nurse looked at me like 'why are you asking me?' This is different in other hospitals, where students sit at one table and staff at another."*

Simple gestures as described above are important to demonstrate to nursing students that they are accepted and that they play an integral part in the care delivery within the clinical areas. Socialising undergraduate nursing students into

the profession is an important part of nursing education and needs to be acknowledged by staff dealing with nursing students, in particular the preceptors. Socialisation is also a complex process, as the participants describe the various challenges they encountered:

FG3 P.10: “You have to wait and see what they (preceptors) are like is it with everyone? Or are they just like that with you because you are a student?”

The complex process of socialisation has been described by Dinmohammadi et al. (2013) as personal, and varies from person to person. When the participants in this study were asked what staff could do to help make them feel more included, they all (i.e. in all focus groups) suggested that being friendly, open and approachable were factors. FG4 P. 9 responded in the following way:

FG4 P.9: “If they are just friendly and chat to you. It’s not even what they say; it’s the smile or the wink. It’s just the little things that can pick you up on a bad day. If you are having a day where you feel you can do nothing right and someone gives you a smile – it can really pick you up.”

In this “‘assimilation’ phase, nursing students described how they adapted to their surroundings was with the help and support of role models. The importance of the preceptor role was reiterated in many ways throughout this study, in keeping with previous research (McCarthy & Murphy, 2010; Myrick et al., 2010).

FG5 P.34: “Staff are our role models – if you work with a nurse who is brilliant, that is what you want to be.”

Participants (in all focus groups) in this study demonstrated an awareness of how the preceptor could help them with socialising and being accepted into the ward.

4.4.2 Phase 2: Appeasement Phase

Participants in this study, while describing how they were socialised into nursing and into the ward or unit they were placed in, admitted that they used a technique which they referred to as “*killing them (qualified staff) with kindness*”. By this, they meant aiming to please and placate their preceptors:

FG1 P.4: *"You have to kill them with kindness all the time. You ask them 'Is there anything I can do? Do you want me to do this now? Is it okay if I do that now?' I basically do anything they want me to do."*

The desire to please and appease preceptors appeared to supersede the desire to please the patient, but was more complex, as it was coupled with the desire to pass the clinical placement assessment:

FG5 P.14: *"What makes a day good for me is knowing that the staff nurse I have worked with is happy with what I have done."*

For this participant, the desire to please the preceptor appears to be the overriding concern:

FG4 P.2: *"Sometimes it feels like that you have to not force yourself on them but put yourself forward every time... everyone is waiting for you to prove yourself"*

Daiski's (2004) study of qualified staff found that participants had a desire to please those whom they perceived to be more powerful. This too was seen in the quotation (FG 5 P.14) where pleasing becomes part of the socialisation process and the nursing student is rewarded by feeling part of the team:

FG4 P. 7: *"you would bend over back ways for them; you would do anything they asked of you."*

Participants were really aware that they needed to fit in and get on with staff in order to have a successful placement. Getting on with staff for participants was interpreted that they pleased them, by doing the work as explained in the quotation below:

FG5 P.16: *"As long as they (preceptors) all know that you are giving it your best shot and get things done then everyone appreciates what you have done"*

However this was not always the case as P. 7 found that frequently appeasement meant that you would stay away if possible or just agree with a preceptor:

FG3 P.7: "Sometimes someone would warn you 'don't go near her... or just agree with her' you just have to work around their personalities all the time"

4.4.3 Phase 3: Chameleon phase

Conversely, participants in focus groups 1, 3, 4 and 5 described the process of being socialised into the nursing world through inhibiting their own personalities. This was not a theme reported in focus group 2. In focus group 1, 3, 4 and 5 participants appeared to conform to the perceived expectation of what staff wanted them to be, and then attempted to become like the staff mirroring their ways. They did this they explained as they felt they would "get on better" on the wards:

FG4 P.2: "Sometimes you feel as though you can't be yourself you have to change. You adapt to their kind of talk. You just have to hide your personality and do anything they tell you."

As noted by Mackintosh (2006), conforming and changing personality in order to fit into a ward is not a new concept in nursing. Participant (FG4 P2) described how she coped with the expectation of conformity in the clinical learning environment. In this study, nursing students were aware of the challenges of socialisation and trying to "fit in". They were eager to please and wanted to belong and be part of the clinical area they worked in. They were aware of their contribution to an already stressed clinical environment, and were anxious to ameliorate these stresses through the provision of labour and by not requiring additional supports:

FG3 P. 2: "It's just easier to go along with it. You're biting your tongue sometimes, but you just have get on with it"

When the participants were directly asked if they felt that they could be themselves as nursing students in the clinical learning environment, the following responses were given:

FG3 P.2: "You definitely change"; "You are not yourself"; "You adapt to their ways."

These participants describe the way in which they change their personalities in order to be fully socialised into the clinical learning environment, which ultimately means full acceptance into the ward/unit. Participants in the quotes FG3 P2 describe how, in order to survive and be accepted into this stage of socialisation, they became like those around them (staff nurses), leading to what they perceive as acceptance:

FG2 P.1: *“A few of them (preceptors) say ‘oh you will wither and be less enthusiastic as the years go on’. One nurse said it to me and she was only six years qualified she admitted to feeling the frustration already after a few years qualified. I’d hate that”*

The danger of the chameleon phase and becoming like those around is that both good and poor behaviours and attitudes are adapted. This means that poor attitudes such as those described by P.1 are multiplied:

FG3 P. 8: *“I’m only new on a ward and one day a preceptor said ‘why are you becoming a nurse?’ I said I always wanted to be a nurse it’s what I enjoy. Now I wonder will I turn into that nurse”*

The consensus of the focus group was that participants mould and become like their qualified colleagues, in order to be “successful” and “fit in”:

FG4 P4 *“You can’t be yourself, if you could be yourself and get on with people it would be great but that won’t work you have to change”*

Clouder (2003, p218.) identified this and referred to this as “*presentation of self*”. Clouder (2003) explains that students need to act in accordance with the generalised expectations of them:

FG4 P. 6: *“To not get on with who you are working with is horrible-you end up dreading coming into work, you get really down in yourself and hate working with her...that happened me and it had an awful effect on me.”*

Participants had all experience of this even if they were not currently experiencing working with someone who they found difficult. Participants’ knew that this was an act of self-preservation that made being socialised into the ward/unit easier. In this study, the participants did what they understood as necessary in order to

socialise into the ward and become part of the staff. Concurring with previous studies into socialisation, participants recognised its importance and challenges (Nessler et al., 2001) and of the importance of qualified staff/preceptors in the process (Campbell, 2003). The importance of the preceptor in socialising the nursing student into the clinical learning environment is evident in this theme. There is also a clearly articulated strategy of the participants in this study of emulating the behaviours and attitudes of their preceptors in order to expedite the socialisation process.

4.4.4 Concluding points on socialisation

The socialisation process in nursing is recognised as being an important and valuable part of nursing (Nesler et al., 2001; Clouder, 2003). Socialising and fitting into the nursing profession was not easy for all of the participants (in all focus groups) in this study but it study varied depending on their interaction with the clinical environment. Each participant experienced different approaches and challenges. The key factors that contributed to the process were: wanting to be accepted into the ward/unit/nursing (phase 1; assimilation), being anxious to please (phase 2: appeasement) and finally phase 3 conforming and changing to become like those that the participants work with (phase 3 chameleon phase). Part of the pressure of socialising was alleviated when the nursing students had a role model who was supportive. However, when that did not happen, there appeared to be no other person the student could turn to. Fitting into the clinical area for the nursing student occurred when they became like the staff, when they '*hide their personalities*' and worked hard to please the qualified staff.

4.5 Theme 3: power /powerlessness

Power is ubiquitous and makes its presence felt in all aspects of everyday life such as school, at home and in the workplace. Many relationships are based on a power differential, either wittingly or unwittingly. Empowerment encapsulates an element of power: power to propel action, power to implement action and power to empower (Kuokkanen and Leino-Kilpi, 2000). As stated in section 1.7.5, power and empowerment are closely related concepts. Theme 3, (Power/

powerlessness) in the present study presents the participants' experience of power/ powerlessness within the clinical learning environment. The concept of power/powerlessness emanated strongly from the focus group interviews and was present as an undercurrent in many of the other themes. As discussed previously (section 3.4.1) many of the themes are experienced in an interwoven and interconnected way reflecting real world experience. However for the purpose of clarity they are dealt with in isolation in this thesis. The findings of theme 3 (power/ powerlessness) are presented using the sub-themes; status quo, vulnerability of nursing students, fear of failure and clinical learning environment (CLE) and context. at the time of the study (Figure 4).

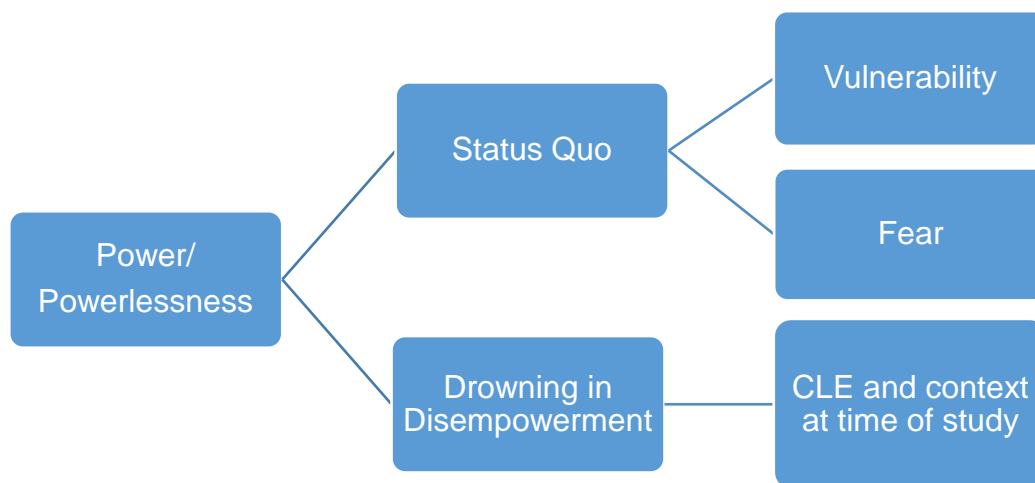


Figure 4: Theme 3: Power/powerlessness

4.5.1 Status Quo

Qualified staff were perceived by participants as being powerful as they were clinically competent and they also fulfilled the role of preceptor and assessor of the students' clinical competencies. Hierarchical power and status was evident from this participant's quotation:

FG1 P.4: "Now you still feel one step under the staff nurses. I hope when I qualify it will go away (the feeling of not being equal)."

Frustration for the participants appeared to be associated with their position within the clinical learning environment hierarchy. They described feeling powerless within the hierarchical power structure:

FG3 P.6: *“You just want your qualification – do your four years and get out and get the power. The minute your qualified you’ll feel different. I’m a staff nurse: now I’ve equal rights and she can’t make my life hell anymore...”*

The participants are aware of their powerlessness and described it in the following way:

FG1 P.2: *“The power balance is very one-sided.”*

Participants accepted their status and did not want to challenge the status quo in the present study. This is in keeping with the critical social theory view of nurses being an oppressed group subject to domination, but seeking liberation from this domination as discussed in section 2.6.3. Manojlovich (2007) contends that powerless nurses are ineffective, but also when a nurse is empowered there is a benefit to the patient. Lack of nursing power, according to Manojlovich and DeCicco (2007), contributed to poorer patient outcomes. This was evident when the participants acknowledged the impact of empowerment and its relation with power on their nursing care:

FG1 P.4: *“If you’re not respected then you’re not working with the person you’re kind of working for that person ... whereas if they empower you, if they give you the knowledge and if they respect what you know and what you can do you will work better.”*

The power to transfer knowledge, respect and empowerment rests with the qualified staff for participants. The powerlessness of the participant’s experiences was evident throughout the study. The following participant (FG4 p.7) explains how difficult it is to cope with feeling powerlessness, and the impact it has on the preceptor-student relationship:

FG4 P.7: *"You could be bending over back-ways doing absolutely everything and then if they think you don't have it done right that's it – their opinion is made of you."*

The participants in the present study felt powerless as described by P.3 FG 3, participants were aware of the fact that their failure to get on with some staff would have negative connotations. Participants acknowledged that they had to 'agree to anything' or 'their life would be hell' and as a result they experienced powerlessness: Contemporary literature suggests that communication with the student is a pivotal role of the preceptor and essential in ensuring the nursing student attains the skills and competencies required for registration (Ousey, 2009). Preceptors need to be aware of the skills that are needed to convey equity and transparency to the relationship between them and the students:

FG3 P.3: *"Oh they (qualified staff) can stop you from qualifying. They can make your life hell and some nurses do and you would be warned about them. 'Oh don't go near that nurse' or 'just agree to anything she says or she'll make your life hell'; and this is not just to students but to staff as well."*

The lack of power of the participants and the fear of "certain" staff is clear from this participant's statement. Randle (2003a) found that nursing students appeared to need power in order to fulfil their role, but it is a negative power and can become destructive. This supports Freire's (2000) theory of how the oppressed become like the oppressors. The following student expressed that on occasions she was powerless in her position and felt used to do the tasks that the staff nurse did not want to do:

FG4 P.7: *"You're treated as a pair of hands. You're just doing the washes."*

The participant (FG4 P.7) in this quotation did not perceive doing the washes as being as important, or as providing her with an opportunity for learning. This idea may be reinforced by assigning the most junior team members (nursing students or health care assistants) to the personal care of patients. Therefore, the value of providing essential patient care, and the qualified staff's approach to patient care were an influence on participants' view of their role and consequently impacted their empowerment in the present study:

FG4 P.11: *“People don’t want to stick their neck out. People (nursing students) just want to get on with it.”*

There was little evidence in this study of participants feeling powerful instead participants were aware of their lowly position as students without power.

4.5.2 Vulnerability of nursing students

Nursing students wear red stripes on the shoulders of their uniforms denoting that they are *student* nurse and a stripe is worn for every year of their programme (1-4). This provides a visual cue to other staff on the ward of the fact that they are nursing students and what stage they are at on the programme. Participants were very aware of their status, as some described in the following quotation:

FG4 P.7: *“I think the red stripes stop you a lot. You just want to keep your head down and get through things and get your qualification. You don’t want to be sticking your head out and causing trouble.”*

In this quotation, the participants are accepting their sense of powerlessness in relation to their clinical assessment with qualified staff, saying that you just have *“work around them”*. There is a sense of vulnerability about the role of the nursing student status that appears to be reinforced by the red stripes. The participants viewed their denotation as *“students”*, which is displayed on their uniforms as red stripes as a barrier to their integration. They expressed their frustration at their status and longed to have *“the power”*, once qualified. Once qualified, the nursing students in this study believed that the hierarchy of power will have dissipated. This study would support the fact that the nursing students appeared to have little insight into the fact that a transition and difficulties may lie ahead as they become the *“newly qualified staff.”* The hierarchical interpretation of power is clearly evident in the following quotation from a participant in the study:

FG5 P.11: *“Once I was having a photo taken on the ward and they asked me what my title was... so I replied ‘student’, and the staff nurse said ‘no you’re not a student you are an intern so you are a step up from a student’...it was nice to know that they appreciated we were a step up from a student...”*

This quotation demonstrates the ingrained low status of being a nursing student and the lack of esteem associated with it, coupled with a complete acceptance of the hierarchical structure, where the nursing student is perceived as being at the lowest level. As nursing education has moved in Ireland into universities and colleges, it is timely that the status of learner and nursing student is challenged and valued in the clinical learning environment.

4.5.3 Drowning and disempowered

On completion of each clinical placement it is important that the nursing students achieve the many competencies and learning outcomes of the undergraduate curriculum. However, the concept of survival and how to “survive” the internship was raised by the following participant, who described what she perceived the final year placement /internship would be like. She said she thought it would involve consolidation of skills and gaining experience, but, this was not the case:

FG5 P.5: *“I thought the internship would be more about development and sometimes I feel it is more about survival. ‘Will I get through this week?’”*

For many participants, the experiences of the clinical placements were very challenging and were really about survival rather than consolidation and learning. The participant below described a very bleak time when she said:

FG4 P.4: *“I was drowning the whole time I was there.”*

For some participants in this study, it was clear that they were struggling to survive in the clinical learning environment. This has been previously referred to in nursing literature (Cusack & Smith, 2010; Suresh et al. 2012; Emanuel, 2013). It is evident, both anecdotally and in the literature that the clinical environment is complex, with both political and social pressures contributing to a feeling of pressure for staff and students (Maben et al., 2006; Curtis et al., 2012). Participants were cognisant of the need for respect and positive communication:

FG1 P.3: *“One of the biggest things in empowerment is respect and communication. I think if you are respected by the staff nurse its half the battle.”*

When participants in this study were asked about who was available to support them, they said that they really just felt they had each other. For vulnerable students there needs to be more palpable support available to them:

FG1 P.2: *“Through being empowered and disempowered you can see what it’s like to be empowered and empower others. With the second years now on placement you know how to enhance their learning by calling them by name....”*

Participants in the present study know that their position is transient and were aware of how to empower those that are currently junior to them.

4.5.4 Fear of failure

Preceptors “examine” and assess nursing students in order to ascertain their competency achievements in the clinical areas. Therefore, they have the ability to accept or deny access to the nursing profession, which in effect makes them the “gatekeepers” to the profession. This contributes to the participants’ fear and anxiety surrounding clinical competency assessment, as echoed in the following comment:

FG1 P.2: *“I know some students have had bad assessments because of a personality clash. I would be afraid to say anything to them (preceptors) because you will not get a fair assessment which means they (preceptors) have an unfair hold over you.”*

They are “the inexperienced” seeking experience and support from the well-seasoned and expert qualified staff. There is a power differential as the qualified staff are the “gatekeepers” to the profession:

FG1 P.1: *“Sometimes you would be just thinking she (preceptor) is going to do my interview (clinical assessment) and she might not pass me...”*

Whether or not nursing students received biased assessment is not the most salient point this participant is making. Rather, what is important is that the nursing students' perception is that their assessment is based on how they get on with their preceptors, rather than their competence in clinical skills and the acquisition of nursing values. There was a certain level of frustration evident in the following quotation regarding knowing how much initiative to demonstrate and not knowing how much or how little independence is required:

FG5 P.21: *"They want you to take initiative; when you take it they pull you back: again you are left wondering..."*

Freire (2000) suggested that most oppressive situations will remain as such until the forces of opposition or disobedience create a change. In order to free the nursing students to practise in a liberated manner, and learn in a non-oppressive way, change will need to occur.

4.5.5 Clinical learning environment and context at the time of the study

Wells and White (2014) describe the scene in Ireland during the economic crisis (2007-2014) in an article entitled "Boom to bust". During these years' staff in healthcare experienced staffing moratoria, cutbacks coupled with increased patient acuity. These conditions made a significant contribution to the challenges of delivering health care. The pressure, according to the participants in this study, appeared to emanate from wage cuts, staff shortages due to a moratorium on recruitment:

FG3 P.3: *"It is very hard for them (qualified staff): they were getting x amount now all their money has been cut."*

Participants in this study (in all focus groups) expressed how they felt under pressure. One participant described the pressure she felt in the following way:

FG4 P.3: *"We talk to each other on breaks. You think you are going to breakdown. The pressure is horrendous!"*

However, participants remained cognisant of the challenges for qualified staff, despite their own stressors. Not only did the nursing students during this period have the same pressures as the staff, they also had the additional pressure of being learners, not being sure, and having to pass their clinical assessment. Despite these confounding obstacles, the participants were mindful of how difficult and challenging these times were for the qualified staff. The findings of the present study support Wells and White (2014), who report that greater than 7% of a wage cut was experienced by many registered nurses during this period. The pressure in the clinical environment between fiscal constraints and staff shortages contributed to a highly pressurised environment. Participants themselves acknowledged their financial burden and how it was difficult for them to feel empowered within the environment and economic climate.

FG3 P.4: "What I am finally coming out with is nothing (money) it's been cut and cut..."

FG3 P.2: "I find it really hard because as a mature student I came back to nursing so when staff are negative about nursing and the career I'm thinking 'this has to work' this is my second degree but it very disheartening"

FG5 P.2: "It's a lot harder now than it ever was before (clinical learning environment) and they (preceptors and staff) do feel sorry for us and do their best to support us through it."

Participants described how they were constantly striving to deliver a high quality of care in this pressurised environment often at a young age:

FG4 P.3: "serious pressure for someone my age."

An early study by Davies (1993) suggests that trying to provide care that is ultimately "slapdash" in nature, because of the environment, means that the student may have a very negative learning experience. Concurring with this, Last and Fullbrook (2003) found that nursing students asked themselves if they actually *wanted* to practice in such environments. Heinen et al. (2013), in a contemporary study of intentions to leave amongst qualified staff, found Ireland had the second highest rate in Europe (11%). Overall they found that intention to leave was

associated with staff burnout across 10 European countries. Nursing students have been subjected to many changes in work conditions, such as reduced staff and skill mix and were clear and unambiguous in their assertion of its impact on their empowerment:

FG5 P.1: *"The biggest obstacle to being empowered is lack of time and the sheer volume of things you have to do."*

The main resource that participants described being short of, in this study was time. Participants described being under pressure to perform, and time was an obstacle and trying to fit into the wards where they were placed. This is supported by Scott et al., (2013), in an Irish study detailing the time pressures on qualified staff. All the participants associated lack of time with a feeling of disempowerment, as seen in the following quotation:

FG5: *"Disempowerment is what?"* (Interviewer)

FG5: (Participants together) *"Lack of time."*

All participants in this focus group answered this together vehemently further supporting their contention about the lack of time for nursing care. Lack of time therefore was seen by participants as a contributor to their lack of empowerment, and also being aware that as learners, and being less proficient than staff nurses, they needed more time. In answering this question 'disempowerment is?' The participants reply was unequivocal and unambiguous. This quotation was augmented by the tone and facial expression validated by both the observer and researcher in the focus group. Jackson (1998) supports the addition of the group dynamic in focus group interviews. The participant (FG4 P.2) in the following quotation explained how difficult it is to cope when you do not have the time you need to provide care:

FG4 P.2: *"You want to do everything but sometimes you just don't have the time and sometimes you just worry about the patients. I suppose it is guilt that you did not have enough time to get everything done."*

This participant revealed the tension between wanting to do the best and knowing that the reality is that there is not enough time. This contributes to emotional

exhaustion. Evidence of the relationship between failure to accomplish patient care and emotional exhaustion a component of burnout is reported in nursing literature (You et al., 2013).

4.5.6 Focus group 2- a deviant case

As stated in section 3.10.2 deviant cases may arise in qualitative analysis and constitutes an important part of data analysis (Patton, 1999). The theme power/r powerlessness emanated as a main theme across all five focus groups. However in focus group 2 a feeling of powerlessness was not expressed by participants and power was seen from the perspective of being an empowering and positive force.

FG2 P.2: “you take ownership for your patients and you want to do the very best for them...you actually feel it’s up to me...now you see them as being your patients and you have to make a difference to them”

In the other focus groups (1, 3, 4 and 5) participants viewed their lack of power and resultant powerlessness as being associated with their status as a student nurse. This was an interesting finding, and is discussed in more detail in section 5.5. In focus group 2, participants perceived themselves as being empowered, they saw themselves as being part of a team/ward/hospital/organisation and felt that they were welcome and belonged as described in section (4.3.3) where one participant said the hospital was like a ‘big family’. In the other four focus groups, participants discussed the difference between the qualified and unqualified staff, of how they felt when they were not included in the ward or team, and also how they felt they could or should not voice their opinions or concerns. Many participants that experienced powerlessness viewed it as being transitory, believing that it would be different once qualified. In focus group 2 the experience of power and empowerment evolved from delivering care. Participants were aware and insightful when asked about protecting this feeling of empowerment:

FG2 P.7: “Recognition from the patient for what you do really impacts your empowerment and also the Director of Nursing to come to us (nursing students) and say ‘Girls you are doing so well –I have heard great things about you’. It really does help us.”

The influence of the Director of Nursing was expressed in focus group 2, but not in any of the others (focus groups 1, 3, 4 or 5). This may have contributed to the empowerment and the power of caring that is evident in this focus group.

4.6 Researcher's voice

Data gathering and analysis were very enjoyable stages of the research project and ones which involved a lot of reflection. Most groups were unaware of their potential, though they filled me with pride as they were so articulate and so passionate about the care they provided to their patients. They often gave complex and in depth scenarios about clinical dilemmas where they appeared to excel. I did not doubt, throughout the interviews, that the calibre of students was very high, and that clinically and academically they were a very bright and able work force. There was ample evidence of this throughout the interviews, however I found myself questioning why they were so powerless and disempowered when they were so very able. I found myself wondering, when a key outcome of nursing education is to produce questioning, confident and innovative practitioners, how we, as nurses and educators, will succeed when questions are stifled and conformity and compliance are common practice within the clinical learning environment.

One focus group in particular was different, and served as a source of inspiration (focus group 2). As detailed previously in section 1.8, data collection coincided in this research project with major financial collapse in the Irish economy. However, one focus group appeared immune to the fiscal and economic climate, describing a protected, close and warm clinical learning environment (as described previously each focus group were hospital specific section 3.9). In focus group 2, participants consistently reported how they could raise above the austerity and adversity that existed in the clinical environment, and did so for the "patient". In addition, their experiences of incivility in the hospital or ward culture did not exist and they were socialised into the nursing culture in an inclusive and positive way. It filled me with admiration for a hospital and staff that could provide such an environment at a time of harsh economic and fiscal restructuring. This interview was important, as it filled me with hope that it could be different, and we could as a

profession learn to support our students to become empowered practitioners of the future.

Sometimes, while listening to the audios and reading the focus group interviews during the data analysis stage, I felt that the powerlessness of the participants' situation was palpable. This was never something I had considered when working in college with the nursing students, who appeared confident and questioned/challenged norms and traditions in college, when necessary. However, the same group on clinical practice presented a very different but lasting impression. They were very aware of their powerlessness, and a worrying thought was that they would become like the qualified staff if the cycle was not broken. Some participants were even aware that they would be "equal" once qualified, such was the power differential. This fear persisted, and remained in my conscious thoughts throughout the research project.

4.7 Chapter summary

Chapter 4 presents the findings of this study. Three main themes are presented from five focus groups. Theme 1 Cultural influences describes how culture was experienced by the participants in the present study. Cultural influences included hospital management and ward culture which are presented as sub-themes. Participants described how the culture of an organisation ward as experienced during clinical placement contributed to how they experienced empowerment. The findings suggest that preceptors contribute to nursing students' empowerment through their support: making them feel included as though they belong. Furthermore, having a preceptor interested in teaching augmented the students' feelings of self-worth. Conversely, feelings of not being needed not being valued, not being part of a team and powerlessness added to a feeling of disempowerment. Theme 2 (Socialisation processes) presents the findings from the present study in relation to how participants described the importance of the socialisation processes and their resultant impact on empowerment. This included the following: assimilation; appeasement and chameleon phases, referring to how participants described another aspect of their quest to fit in, and belong, through appeasement and striving to please the preceptor. Participants in the present study viewed the socialisation process as a significant contributor to their level of

stress, and sometimes distress, while on clinical placement. Participants' descriptions of how they were socialised into a new ward routine and to new colleagues unveiled the difficulties that nursing students' experience. In the present study challenging conditions and oppressive nursing cultures and negative behaviours impacted participants' level of empowerment and disempowerment.

Theme 3 presents findings from the study in relation to power/ powerlessness. Participants in focus groups 1, 3 4, and 5 were conscious of their lack of power within the organisation, and did not feel that they could represent themselves as equals with qualified staff. This was partly due to the hierarchical power structure and not wanting to challenge the status quo. Powerlessness was also experienced when participants explained what disempowered them exposing their vulnerability as learners. The participants were also made feel more vulnerable through expressing fear of failure as the clinical assessment was completed by preceptors vulnerable through disempowerment. The timing of this study and the context are discussed in relation to what participants described in relation to the climate at the time of the study. Focus group 2 is discussed as being a focus group that was different to the others in terms of the participants' expression or lack of it in relation to power and powerlessness. Focus group 2 experienced a clinical learning environment where an overall sense of empowerment appeared to protect participants from feeling powerless. Within focus group 2, participants described what they could achieve through their work as student nurses. They detailed how, through their empowerment, they were focusing on patient care and working through difficulties that existed.

The subsequent chapter will discuss these findings together with the relevant literature on the topic of empowerment and nursing students' clinical practice.

Chapter 5: Discussion

5.0 Introduction

The previous chapter presented the findings of this study, indicating what participants found empowering and disempowering in clinical practice. This chapter presents a discussion of the key findings from this study, drawing on contemporary, relevant and theoretical literature.

In an educational context the clinical learning environment's primary function is to support practice-based learning for nursing students within their programme of nurse education. Learning in practice is a key component of nursing (Koontz et al., 2010), and the importance of clinical learning is reflected in curricula, with up to 50% of time of many nursing programmes dedicated to practice and placement (Emanuel, 2013). The clinical learning environment is critical to the development of the nursing students' professionalism through the development of professional behaviours and the development of strong ethical values (Sabatino et al., 2015). This chapter discusses specific elements that influenced empowerment and disempowerment within the clinical learning environment and includes a discussion on the contribution of culture (section 5.1), the preceptors' influence (section 5.2), a culture of incivility in the clinical learning environment (section 5.3) and the impact of socialisation (section 5.4) on nursing students' empowerment or disempowerment. The subsequent section (5.5) discusses the influence of power and powerlessness in this study together with relevant and seminal research. This section of the chapter concludes with a comment on the impact of the economic downturn experienced in Ireland during the lifetime of this study (section 5.6).

Section (5.7) presents a discussion on the contribution of the theoretical literature in this study in relation to the findings. Each of the domains (Layder, 2006) is discussed separately with relevant examples from the study are provided to demonstrate how Layder's theories (2005 & 2006) are used in the study to maximise the richness of the qualitative data. The following sections describe this process: domain of psychobiography, domain of situated activity, domain of social

activity and domain of contextual resources. The relevance of power in relation to the domains is also discussed. This chapter concludes with a chapter summary.

5.1 The contribution of culture to empowerment

This study demonstrates that empowerment for nursing students was influenced by both organisational/management and ward/unit culture. It is evident from this study that nursing students experienced nursing culture at two levels: firstly as nursing students interfacing with a micro culture (ward/unit), and secondly through their experience of being part of ward/team within a larger organisation/hospital and working within that larger culture (see section 4.3). In relation to the theme of culture, awareness of context and background is important to furthering ones' understanding of the clinical learning environment, this is acknowledged in section 1.2 (historical context) and in the methodology selected for the study (Chapter 3). Culture is a not always visible or tangible and is expressed according to Suominen et al. (1997) through beliefs, knowledge, convictions, morals and laws and not just through practice and rituals. Suominen et al. (1997, p. 186) stated that:

“Culture finds expression in learned, shared and inherited values, in the beliefs, norms and life practices of a certain group, guiding their processes of thinking, decision making and action.”

According to Brown et al. (2013), though there is much literature on nursing culture, literature that specifically focuses on nursing students and culture is sparse. Interestingly, Bradbury-Jones et al. (2010) reported that culture was a 'sphere of influence' that impacted nursing students' empowerment. Nursing culture has its own specific language, rules, rituals and dress code (uniform). It is important to highlight that these are the observable or visible signs of culture and not culture in its entirety. Schein (1990) compares culture to an iceberg, in that it is deep and difficult to detect. There are also visible and invisible aspects to culture. Using this analogy, the visible culture includes rituals, practices and norms, whereas the invisible signs of culture comprise values, attitudes, beliefs and feelings. The deeper unobservable core of culture is important to how people within an organisation feel and act (Schein, 1990). This deeper aspect of culture

is very important, often harder to articulate, but a very powerful and tangible element of what being part of an organisation means for employees.

Nursing students' experience of empowerment while on placement is presented in section 4.3 and describes a variety of experiences specifically regarding the impact of organisational/hospital and ward/unit cultures. The findings of this study show how important organisational/hospital/ward/unit culture was for nursing students and demonstrated how the nursing students were regarded within their respective hospitals. This in turn influenced how nursing students perceived they contributed to the ward/unit and how they approached patient care thus influencing their empowerment. Therefore the influence of culture cascaded downwards from the organisation/hospital to the nursing student at ward or unit level. The importance of culture is therefore important for academic staff, clinical staff and nursing students. It is also evident that nursing culture values and beliefs need to be congruent with educational curricula and nursing board's philosophy. If this is not the case the nursing student will receive very conflicted messages. The nursing student will adopt the culture that he/she is exposed to in order to be socialised and accepted. Therefore, the aspect of culture that is invisible, that is not observable, is an important influence on empowerment as was demonstrated in the context of the study. Aiken et al. (2012) identified that, where the practice environment was reported as being positive (i.e. managerial support for nursing care, good doctor-nurse relations, nurse participation in decision-making, and organisational priorities on care quality), there was a significant association with patient satisfaction, quality of patient care and positive nursing outcomes. In the present study positive culture and empowered staff impacted how the nursing students approached patient care. The reverse is also true in that the ramifications of a culture that is oppressive for staff may result in staff burnout (Aiken et al., 2012), stress and high attrition (Barniball et al., 2012) can impact nursing students ability to become critical thinkers (Forniers and Peden-McAlpine, 2007). Most importantly as is evident in the Francis report (House of Commons, 2010) empowered staff impact patient care. This was also evident in the present study where nursing students expressed not wanting to become like their preceptors preferring to retain their enthusiasm and their love of nursing (section 4.3).

At another level, nursing students in the present study described *the difference* an individual member of staff (section 4.3) made to their empowerment on a particular day, thus influencing the ward culture. Nursing students clearly described the contributing factors to empowerment and disempowerment in relation to culture, outlining two different types of clinical learning environment culture in the focus groups: firstly a culture that encouraged and stimulated empowerment and secondly a culture that appeared to disempower the nursing students through oppression and negativity. As was evident in this study, empowered nurses derive meaning and satisfaction from their work (section 4.3.3), also identified by Aiken et al. (2012). This means that when the practice environment is positive and supportive, the quality of care and satisfaction with care delivered are improved. In addition the findings of this study reported how nursing students when empowered felt their contribution made a difference and highlighted the positive affect that has on the nursing care they provided (section 4.3.3).

In light of the global nursing shortage it is imperative that efforts are made to retain staff and sustain a lifetime career in healthcare. In order to do this it is necessary to ensure that staff are empowered and cared for within the healthcare system. Many contemporary studies describe difficulties with retention of staff in the current environment (Duchscher & Myrick, 2008; Aiken, 2012). However, retention of nursing students and qualified staff is now vitally important, as the healthcare system grapples with the current global retention crisis. The experiences of nursing students whilst on clinical placement have lasting influences on future career choices (Spouse, 2000) and nursing students' intention to discontinue (James & Chapman, 2009). International studies show that many nurses are dissatisfied, suffering stress at being unable to complete their nursing care, which further compounds the burnout and stress (van Bogart et al. (2009) and Heinen et al. (2013). In addition, there is growing acknowledgement in the literature that the environment in which care is provided, impacts job satisfaction and staff retention (Coomber & Barriball, 2007; Hayes et al., 2012; Norman 2013). This may also, it is suggested, affect how care is delivered (Laker et al., 2012). Therefore the culture of empowerment and environment where care is provided is important, and worthy of the attention of both academics and clinicians.

The findings of this study demonstrated that when culture was supportive nursing students appeared more empowered. Focus group 2 appeared to experience a consistently more inclusive and supportive culture than that of the other focus groups, where a supportive culture was more unpredictable and less evident (FG 1, 3, 4 and 5). This is interesting, as all hospitals involved in the study are governed by the same umbrella organisation, the HSE (see section 1.2.2). Therefore, the visible signs of culture associated with a large organisations, in terms of “the way things are done here” including nursing management policy and approach to staff, would be similar. The more invisible signs of culture i.e. what it feels like to work in a particular hospital culture were different for participants in all focus groups. In the present study, both the visible and invisible components of culture were of interest.

In focus group 2, a culture of support and encouragement was described throughout the hospital, and nursing students described how this impacted their empowerment. Nursing students in this focus group (2) described the influence that this type of support in the clinical learning environment had on them and how their empowerment impacted patient care (section 4.3.3). It is also interesting to note that this focus group was the only one in which participants described the influence of the Director of Nursing as being relevant to them, by demonstrating an interest in their progression on the programme and through meeting with them. The findings of this study support the findings of Kuokkanen and Leino-Kilpi's (2001) study of the characteristics of an empowered practitioner. They found that the following characteristics promote empowerment: moral principles, a nurse who treats others with respect, acts honestly, acts justly, personal integrity, looks after his/her own wellbeing, dares to say and act, acts effectively under pressure, acts flexibly, acts skilfully, makes decisions, acts independently, consults and teaches colleagues, finds creative solutions, promotes new ideas, sociability, works for common goal and solves problems. These qualities are important for empowerment and are needed to create a culture where empowerment can flourish. Supporting the findings of McKimm and Wilkinson (2015) this study suggested that preceptors need to see themselves as leaders and as such capable of positively influencing culture and therefore the experience of nursing

students on clinical placement. The findings of this study would suggest that a positive culture affects how empowerment is experienced by the nursing students.

5.2 Preceptors influence on empowerment

The contribution of the preceptor to the clinical learning environment is undisputed in the nursing literature and is contingent on exploiting the preceptors' expertise and experience in order to identify key learning opportunities for the novice (Newton et al. 2009; Butler et al., 2011). The personal characteristics of preceptors who demonstrated an empowered approach to nurse education was evident in some descriptions of what impacted the culture and environment (see section 4.3). In order to belong and feel part of the team, participants expressed the need to be shown respect and trust in order to develop self-worth. Participants in the present study described the importance of respect for their contribution in providing patient care differentiating between working for the qualified nurse (when respect is absent) as opposed to with (when respected). Laschinger and Finegan (2005) found that trust and respect are associated with positive outcomes for both staff and patients. Staff, they argued, who are distrustful engage less with students and contribute to less to their learning than those who experience high levels of trust thus impacting their sense of self-worth and empowerment.

Nursing students also acknowledged mirroring the attitudes and behaviours of their preceptors (section 4.3.2). This type of role modelling is desirable when the behaviours include empathy, caring and compassion. If however nursing students are developing what Mackintosh (2006) refers to as an 'occupational personality' where there is a disengagement with emotion in order to survive in nursing/healthcare this poses a serious threat to the development and sustainability of compassion in nursing. This was expressed by nursing students in the present study as they reported not wanting to become less caring. In addition they were cognisant of the likelihood of this happening as their preceptors alluded to this possibility (section 4.3.2). This is a theme that has been raised in contemporary literature, Mackintosh (2006, p. 960), who identified in a British study that nursing students reported learning to "care-less" in order to cope with the demands of the role. There is evidence to support this in the present study,

where nursing students stated that their preceptors expressed how they too had been like the students at the start of their careers (i.e. full of enthusiasm), but this was a transient stage and staff acknowledged that it does not last.

The findings of the present study found that preceptors are essential to helping nursing students feel more included. Price's (2009) study acknowledged the importance of the interpersonal relationships between nursing students and their preceptors, coupled with a positive method of communication, as significant contributors to the socialisation processes. Empowerment occurred when preceptors expressed and demonstrated an interest in the nursing students' learning. When preceptors were empowered, this had a positive influence on participants' empowerment (section 4.3.2). This demonstrates how empowerment can be encouraged and stimulated within the clinical learning environment. This is supported by other contemporary studies that suggest the role of the preceptor is paramount to the success of the nursing student on placement (Pellatt, 2006). Levett-Jones et al. (2009a), in an Australian study of 18 nursing students, found that staff-student relationships are pivotal to students' experience of belonging in the creation of a positive experience on placement. This relationship included the provision of emotional support and legitimisation of the nursing student in a learning role. This is supported by the findings of the present study in relation to how the preceptor's role was so important to the nursing students. Nursing students in the present study valued any interest shown to them by their preceptors in their learning, feedback, of being needed and teamwork as key elements in promoting their empowerment. Cooper et al. (2015) in a recent Australian study of what constituted the facilitators of learning environments for first-year nursing students found that the presence of a positive culture of learning was influenced in the preceptor by the understanding the students' role. Bradshaw et al. (2012) suggested that further education and support of preceptors in their role is needed. These findings support Chesser-Smyth and Long's (2013) study that advocated support of nursing students as being pivotal in enhancing their self-confidence while on clinical placement and in addition suggest that the lack of support causes disempowerment which can stifle critical thinking, problem solving and decision making. The importance of the preceptor having a good interpersonal relationship with students was supported in the present study. A

positive relationship increases understanding of both roles and therefore facilitates greater understanding by both parties. This contention is supported by Newton et al. (2009) and Richards and Bowles, (2012). In addition, Ousey (2009) found a good preceptor, will support, listen, reflect, teach, encourage and respect the nursing student. In the present study (see section 4.3.2) nursing students said they felt that once their preceptor was empowered it augmented their learning and empowered them for future practice.

Positive preceptorship was valuable source of empowerment and was dependent on having a good role model. The present study would strongly advocate that the role of the preceptor be supported and safeguarded in order for the future generations of nursing to reap the benefits of such a relationship. The role of the preceptor would appear to be pivotal to empowerment of nursing students and impacts their socialisation and experience into the nursing profession. Emanuel (2013) suggested that there is an unpredictability in the experiences of nursing students within the clinical learning environment and not all nursing students in this study experienced a supportive preceptor. The challenges to the role of the preceptorship are discussed in the following section.

The role of the preceptor is not without its challenges (McCarthy & Murphy, 2010; Gallagher et al. 2012). The findings of this study suggest that nursing students' experienced a variety of positive reaffirming preceptorship and also experienced challenges with preceptorship. The challenges of the preceptors' role highlighted in the study were predominantly attributed to a lack of dedicated time for the support of nursing students this impacted how participants viewed their presence on the wards/units. Some nursing students felt they would be wasting preceptors' time (section 4.3.2). The nursing students in the present study expressed that their priority was to pass their placement and to "get on" with staff. This needs to be placed within the context of other demands on the nursing students as being learners in a new environment and trying to cope with the emotional demands of nursing. Learning the skills and art of nursing and being part of a learning programme did not appear to be a priority for the nursing students in the study. One nursing student described how she did not feel she could ask a question (section 4.3.2) and also that a student was too much of a burden for the ward to

contend with. All of these components contributed to a stressful engagement with preceptors for nursing students who were aware of the pressures on preceptors rather than prioritising their own learning.

Many research studies suggest that a lack of time, stress and support are common challenges for preceptors (McCarthy & Murphy, 2010; Natan et al., 2014). No additional rewards or recognition in time or remuneration are given to preceptors in Ireland, unlike other countries such as the United States. This means that teaching and learning are provided in what McCarthy and Murphy (2010) described as an ad hoc approach. The burden on preceptors is considerable, and qualified staff are expected to precept nursing students, irrespective of whether or not they have expressed an interest in the role (NMBI, 2016). The impact of poor preceptorship and lack of empowerment as a result was seen in the present study and supports previous studies such as Newton et al. (2009) and Natan et al. (2014). Exposing nursing students to preceptors who do not or cannot facilitate empowerment in clinical practice incurs a cost to nursing student education and ultimately practice.

The role of the preceptor is important to nursing student learning, while it is acknowledged to be both demanding and complex from the preceptors' perspective. Myall et al. (2008) found in a study that more than half (68%) of preceptors experienced constraints within their role. Many preceptors are reported according to current literature report being under-prepared for their role (O'Driscoll et al., 2010; Chang et al., 2015). Other studies suggested that preceptors are unsupported in their role, without enough time to fulfil their role in supporting nursing students in the clinical learning environment (Natan et al., 2014). McCarthy & Murphy (2010) found that lack of time and workload were the dominant issues that impacted on the preceptor's ability to provide support to nursing students. Lack of time, increased patient acuity and increased workload are part of the preceptors' challenges (Pulsford et al., 2002; Dolan, 2003; Myall et al., 2008). This lack of time is manifest when preceptors did not have time to feedback to participants in the present study. It is clear from the participants' contribution to the present study (see section 4.3), that the role of the preceptor is difficult and challenging, and there appears to be little recognition of the

challenges of the role in terms of dedicated time to nursing student education. Some of the difficulties in the preceptors' role arise from the joint responsibility of the preceptors' to both patient care and nursing student education without due recognition of the complexity of either role. In addition the environment that the preceptors work in including the culture and the power structure impacts their own empowerment. Findings in the present study support the importance of the preceptor to nursing student empowerment. It is also suggested that the pressure arising from the role of the preceptor (section 4.3.2) impacted the preceptors' ability to contribute to the empowerment of the nursing students.

Smith (2014) argued it is time to revisit empowerment in order to address the complexities of the nursing environment and suggested that the basic concept of providing care for others cannot be addressed if there are tensions where unmet personal needs of those providing care are causing a personal disconnect. This resonates with the unmet needs of the preceptors raising questions as to whether or not it is reasonable to expect preceptors to provide care for patients while nurturing and supporting nursing students. Cooper et al. (2015) while exploring the key influences of clinical placement for nursing students supported these findings, when they acknowledged the importance of the key influence of the supervising nurse or preceptor. Campbell (2003, p. 426) advocates that the time has now come for qualified staff to accept responsibility for encouraging and supporting nursing students in their role. It is suggested that preceptors need time in order to support learners and nursing students through reconnecting with how they themselves learned, and through being empowered in their practice. This would aid nursing staff in including nursing students in the nursing team, and promote a culture of inclusion and belonging. Time dedicated to preceptors and qualified staff on self-awareness and recognition of self in others may also promote inclusion and belonging, and contribute positively to the socialisation and inclusion of nursing students into the clinical learning environment.

The quality of positive preceptorship and the contribution of the preceptor to the nursing students' empowerment is a major factor in this study. The education and clinical support of preceptors needs to reiterate and acknowledge how important their contribution is to nursing students. Empowering and protecting the

empowerment of staff is a worthwhile and beneficial exercise, considering its impact on subsequent generations of nursing students. It is essential therefore, that nursing students are educated in an environment that will promote positive experiences from which nursing students can become empowered and learn. The empowerment of nursing students is fundamental and impacts care delivery, retention, intention to stay on the nursing programme and the nursing students' confidence and self-esteem. Nursing management needs to be cognisant of the challenges in the role of preceptors, and their struggles within the clinical learning environment, in order to positively impact empowerment for nursing students.

Nursing students in the present study reported wanting to “do” something to help, in relation to providing patient care, and in the process provide much-needed help and support to their preceptor. They did this they reported, so that they felt needed. However, on occasions, the contrary experience was also reported by nursing students, who stated that they also felt like a burden. If, preceptors do not have a particular interest in teaching, it is a source of concern. All preceptors currently in Ireland are obliged to precept and teach nursing students (NMBI, 2016). However, it is acknowledged that preceptors require more support with this role and this would benefit the student experience specifically if delivered by academics (McCarthy & Murphy, 2010). Feeling like a burden or an inconvenience has also been reported in international literature and the resultant impact is undisputed. Myall et al. (2008) in a contemporary study from the United Kingdom found that when students felt like an “inconvenience” and “burden” it can have far reaching effects and that this can lead to some nursing students withdrawing from the programme of nursing. In the present study, one nursing student referred to the damage such disempowerment can cause (section 4.3.2). The ‘damage’ of disempowerment to the individual nursing student impacts on how they feel about their role and how they perceive their contribution in terms of the nursing care is received. Nursing students reported the need to feel valued by their preceptors whose attitudes and values they mirrored. It is therefore important that support is put into place for preceptors and due recognition given to those preceptors who are motivated and interested in supporting nursing students on placement.

5.3 Incivility in the clinical learning environment

The findings of this study found disempowerment and incivility within the clinical learning environment were experienced (see section 4.3.2). These findings support Daiski (2004) study where he found that nursing students craved affirmation and praise for their contribution. In the present study, many students verbalised their vulnerability and the difficulties they experienced trying to fit into the nursing role and profession. Low self-esteem is commonly associated in the nursing profession and is also associated with oppression and professional socialisation, according to Mooney (2007). Mackintosh (2006) in a study of how nursing students care, found that in order to be socialised nursing students reported caring less in order to be accepted more into the ward.

Oppressed group behaviour is not a new phenomenon in nursing and was described by Freire as far back as 1970's. In respect of this Freire (2000) theorised that the oppressed self-loath and suffer low self-esteem, and that in order to feel better and be successful, they develop the characteristics of the oppressor. The influence of preceptors was such that through imitating their behaviours, whether positive or negative, the nursing students began to feel as if they belonged. Randle (2003b), reported in a study of nursing students' self-esteem, that preceptors have the most influence on the nursing students. She acknowledged that occasionally nursing students may feel pressurised into suppressing their beliefs in order to be accepted.

The impact of the historical legacy on nursing, and an apparent continuation of a hierarchical type of culture in the profession, continue to have an impact and cannot be dismissed in light of the findings of this study. The impact of an oppressive culture in this study impacted participants' experience of the clinical learning environment and was disempowering. This culture, if unchallenged, facilitates qualified staff to behave in this manner and may lead to situations where incivility becomes acceptable and normal and is therefore accepted by staff or students. It is interesting to note that more contemporary research highlights these "hierarchical relationships", reported by Duchscher and Myrick (2008) and Hollins Martin and Bull (2010) prevail in nursing and midwifery to this day

(Canadian and UK studies respectively). The capacity of nursing students to question such behaviours is fundamental to driving change within the clinical environment and needs to be promoted through education of staff and nursing students. It was evident in this study that nursing students did not wish to question behaviour preferring to get through placement and pass. Timmins and McCabe (2005) found that when nurses acted in an assertive manner, it appeared to conflict with expected and societal norms of a “caring nurse”. It was a concern in this study that nursing students described adapting without question to their preceptors behaviour. This raises a legitimate concern which is are nursing students so anxious to fit into the workplace that will they focus on pleasing and conforming, rather than questioning and querying.

Hollins-Martin and Bull (2010) found in a study of registered midwives that socialisation in nursing/midwifery culture involved acquiescence to the hierarchy and furthermore noted that conforming behaviours are commonplace. The nursing students were not aware in the present study that such conformity and acquiescence may continue once qualified. This conformity and lack of questioning is the antithesis to critical thinking and questioning practitioners that are required in the current health care system. It is imperative that nursing students learn to critically appraise information in order to be capable of responding to the challenges of healthcare in the future. Preceptors and educators need to be aware of this type of conformity and encourage nursing students to be assertive and independent thinkers.

Campbell (2003, p. 423-426) suggested that though many aspects of nursing have changed through the years, the one constant is nurses’ poor treatment of one another. Roberts et al. (2009, p. 290), however, refer to this culture simply as “*lacking in support*”. The findings of the present study support other contemporary literature (Campbell, 2003; Randle et al., 2009a). Smith (2014) supports the aspiration of empowerment in education and practice through nurses being more respectful of each other, and advocates that individual differences are recognised and respected. Nurse-to-nurse discrimination and oppression demonstrates the lack of empowerment in nursing, according to Smith (2014). As indicated in section 4.3, evidence from the present study suggests that the culture in the

clinical learning environment for nursing students can be challenging, and incivility towards nursing students was present. Roberts et al. (2009) researched oppressed group behaviour in nursing, and found that nurse managers can improve these behaviours and improve the culture within the workplace. A concerning finding with the present study was that some nursing students described how challenging they found the culture, and its resultant impact on them. Nursing students referred to feeling as if they were “drowning” and feeling like a burden (section 4.5.3). Culture however also impacts patient care: Findings from the present study demonstrated that empowerment of preceptors and managers impacted empowerment of nursing students (section 4.3.2). Further evidence of the importance of culture was endorsed in the Francis report into Mid Staffordshire Trust hospitals (House of Commons, 2010) that demonstrated the importance of culture to patient safety according to Scott et al. (2014).

“This breakdown in nursing care and professional nursing culture had a profoundly detrimental effect on patient care, leading to basic physical and psychological neglect of very vulnerable patients, loss of dignity, distress, injury, and in extreme instances it led to patients’ death.” (Scott et al., 2014 p. 8)

Therefore culture and its relationship with patient care is a very important and significant predictor of safety within a hospital. Organisational/hospital/ward and unit cultures that encourage critical thinking, questioning, new ideas and creative solutions are needed. The presence of nursing students in the clinical learning environment should bring change and innovation to the clinical learning environment. Stifling cultures smother and extinguish the drive for change that students bring. Nursing literature documents many accounts of deficits in the clinical learning environment, as experienced by nursing students, and this is supported by the findings of the present study (Chan, 2002, Papp et al., 2003; O’Driscoll et al., 2010; Sabatino et al., 2015). In the present study, this was seen in how the nursing students viewed themselves being aware of where they were situated within the hierarchy, and wanting and striving to be treated equally. This was further compounded by a feeling of gratitude and appreciation towards those who were interested in teaching and provided support to the participants as they learned (section 4.4.2). There was no sense of entitlement or expectation on

behalf of the nursing students that this was the way it should be. This is perhaps further proof of the issues concerning self-esteem in nursing students that support the findings of the present study (Levett-Jones & Lathlean, 2008). What is concerning in the present study is that nursing students did not view the behaviour as maltreatment, but had actually accepted and normalised it. The question needs to be asked: if nursing students fail to experience care and empowerment during their training, can they demonstrate such behaviours and attributes once qualified?

A concern in the present study was that participants on some occasions described being poorly treated and subject to what appeared to be unreasonable behaviour by qualified staff. One nursing student in the present study described occasions of being criticized and verbally abused, or as she termed it, being “put down” in front of others (section 4.3.2). It is also of concern to note that while the term “bullying” was not used directly by participants, an environment of conflict and incivility was described by some, supporting a previous study finding by Randle (2003a). This type of behaviour, if repeated, may lead to bullying, or if allowed to continue or go unchallenged, could have damaging effects on nursing student empowerment. Bullying is defined by Cooper et al. (2011, p. 2) as:

“long-term aggressive or negative acts or behaviours, carried out repeatedly over time, and directed at someone who finds it difficult to defend him/her self because of a relationship with the bully that is characterised by an imbalance of power”.

The participant in the present study did not refer to this behaviour as bullying, nor did she state that she felt that she was bullied. However, if allowed to continue unchallenged the repetition of this type of behaviour may result in bullying. In addition it is possible that acknowledging the literature on incivility towards nursing students (Shanta & Eliason, 2014) even if the nursing student did feel bullied she/he may not report it. Roberts et al. (2009) described bullying as belittling and downgrading others, impacting both self-esteem and job satisfaction, and suggests there is a paucity of research into the subject in nursing (Randle, 2003a). Supporting this definition, Daiski (2004), Roberts et al. (2009) Laschinger et al. (2010b) and Thomas et al. (2015) describe a culture of incivility and conflict in

some nursing environments. “Civility” is defined by Clark and Carnasso (2008, p.13) as:

“...an authentic respect for others when expressing disagreement, disparity, or controversy. It involves time, presence, a willingness to engage in genuine discourse, and a sincere intention to seek common ground”.

Civility is a foundational aspect for professionalism, according to Shanta and Eliason (2014). There was evidence in the present study of episodes of incivility and behaviours that nursing students found difficult to contend with. The impact of this environment may have long-lasting effects on nursing students. Thomas et al. (2015) in a study of 26 nursing students outlined how nursing students struggled to cope with incivility in the clinical learning environment. Lash et al. (2006) found that verbal abuse of nursing students while on placement made them consider leaving the programme, and many of these types of incidents went unreported. While, Daiski (2004), in a Canadian study, found that lack of support and respect for each other in healthcare settings was common amongst qualified staff, and was perceived as being particularly focused at degree educated staff.

Many research studies have documented the long trajectory of incivility within nursing culture (Randle, 2003a; Roberts et al., 2009; Gillen et al., 2009; Laschinger et al., 2010b; Laschinger et al., 2016). However, both a supportive clinical learning environment and incivility in the nursing culture were experienced by the nursing students in this study. Nursing students in this study were disempowered when they experienced incivility and poor behaviours within the clinical learning environment. This proved to be very challenging for them and they articulated how they felt when they experienced this poor treatment (section 4.3.2). The findings of the present study echo the findings of other research (Randle, 2003a; Daiski, 2004; Gillen et al., 2009; Shanta & Eliason, 2014) in finding an oppressive type of culture that could and should be doing more to welcome nursing students in order to ensure that their clinical learning experience is positive and empowering.

It would appear, therefore, from the findings of the present study and in consultation with the literature that the clinical learning environment remains challenging for nursing students, who depend on their clinical placement to learn from role models/preceptors on how to provide nursing care. The expectation is that within the clinical learning environment positive behaviours and supports are available (Sabatino et al., 2015). It is important, therefore, that if behaviours and environments are challenging and incivility is present in the clinical learning environment culture, that a change is required.

Concluding thoughts on cultural influences

The challenge in nursing education and practice is to provide quality and compassionate care to patients and to demonstrate this to nursing students during their time on clinical placement in order that they will learn to emulate. However, it is unlikely that it is possible for nursing students to witness best practice within a hierarchical and oppressive type of culture. This study supports both the literature and anecdotal evidence that culture in nursing can be challenging. Emanuel (2013) suggested that in order to address these challenges of an oppressive/hierarchical culture, as presented in (section 4.3) nursing students need to be empowered and supported in clinical practice. Conformity and acquiescence should no longer be acceptable or encouraged in nursing. A suitable candidate for nursing is one who asks questions and retains a spirit of inquiry, which may mean not conforming to rituals and customs. It is important therefore to ensure that the learning environment where nursing students are placed for the clinical practice component of their nurse education is an empowering environment, and that staff are aware of the impact of their actions on nursing students' empowerment. Nursing students should and need to be facilitated to question; self-esteem needs to be nurtured and conforming behaviours by nursing students contested. In order to do this the culture in nursing needs to change.

5.4. The impact of socialisation on empowerment

Socialisation of undergraduate nursing students is a vital part of their development, and was first introduced in the literature as early as 1958 (Tradewell, 1996). According to Brown et al. (2013), many sociologists debate the precise location of the socialisation process. Whether it occurs in the classroom or in the clinical arena is unclear in the literature (Nesler et al., 2001; Brown et al., 2013). It is also possible that lack of clarity regarding where socialisation occurs contributes to the challenges of nursing students being socialised into the profession. Page (2005) contended that the educational environment is responsible for socialisation, while the informal part (values and attitudes) are learned through learning on the job and participation. Howkins and Ewens (1999) and Dinmohammadi et al. (2013) suggested that the pattern of socialisation in nursing is irregular and unpredictable, it is non-linear and involves stopping and starting at various milestones and junctures along the way. It is also an individual journey and the individuals involved bring their individuality and personality to the clinical learning environment. The importance of how nursing students are socialised is evident in the literature. Chesser-Smyth (2005) noted that socialisation to the profession influences how the student learns during his/her time in clinical practice. How nursing students become part of the nursing culture and assume their role as learners in the clinical learning environment is through the socialisation processes (Dinmohammadi et al., 2013). Socialisation into the clinical learning environment was a source of anxiety that caused nursing students significant concern on occasions in the present study. However nursing students were aware of what they did in order to make to process easier and had a strategy that they used to help them with socialising into the hospital/ward and profession which is presented in Chapter 4 section 4.2.1). It is also important to note that as nursing students become socialised into a clinical area they are also being assessed on their performance and competency. There is no recognition within the clinical learning environment for socialisation to occur devoid of assessment in the context of this study. Therefore it is clear that from the nursing students perspective that assessment is always a priority and the focus is not on the socialisation process but rather is placed on 'getting on' with staff.

Contemporary literature states that professional socialisation, involves the subconscious internalisation of customs, values, beliefs and professional responsibilities (Dinmohammadi et al., 2013). Melia (1987) in a classic study of 40 nursing students described how nursing students are socialised into the profession by getting the work done and fitting into the ward. Mooney (2007) found that newly-qualified nurses, in an effort to “fit in”, appeared busy and mirrored the work ethic and behaviours of their senior staff. In support of Melia’s (1987) and Mooney’s (2007) findings, the present study found that nursing students described conforming to the behaviours of those around them to ensure that they did not “look” different, and consequently strove to mirror the behaviours of the qualified staff (Chapter 4, section 4.2). This is in keeping with, and supports, Bandura’s social learning (1986) and is further supported by Sabatino et al. (2015) in an Italian study of nursing students, who suggested that nursing students will conform to the behaviours of their role models. This ultimately ensures that they are accepted, socialised and transitioned into the clinical environment. This suggests that in the three decades since Melia’s study (1987) little has changed for nursing students’ socialisation process. Nursing students in the present study were clear on the strategies they employed to help them with the socialisation process in the clinical learning environment and also provided key learning on what behaviours empower and positively impact the socialisation process from the perspective of the preceptor towards them (section 4.4).

Nursing education, through exposure in the clinical learning environment and positive socialisation processes, needs to foster a more open and inclusive attitude to nursing students. Socialisation is an important process for nursing students as it contributes to their life-long professional identity that will sustain their career in nursing. Increased awareness of the socialisation process by preceptors and ward managers would facilitate an easier process for nursing students to be socialised into a more caring profession. The principle aim of nursing education is to educate nurses to become caring, clinically competent and dynamic decision-makers (McCarthy & Murphy, 2008). If, however, through the socialisation process into the nursing profession, nursing students are reporting practising conformity and compliance (section 4.4) there is an issue worthy of investigation within the clinical learning environment. Conforming behaviours

present an area of concern, as many of the high profile inquiries of the last decade demonstrate such as the Francis Report (House of Commons, 2010) found a negative culture where the focus of care was not the patient but rather on the budget. The culture described in the Francis Report was also found to be lacking in terms of critical thinking and openness. Within this context this study the nursing students focus was on being accepted into the ward/hospital/organisation. Being accepted equated to being included and being needed and being part of the ward and therefore nursing students focussed on what they needed to do in order to be socialised into the ward/ hospital/organisation and ultimately profession of nursing. A questioning, inquiring mind is to be expected and encouraged in a population of young learners. Nursing education needs to address these complex issues of compliance and critical thinking, in order to ensure that the empowerment of nursing students in practice is an expected and achievable outcome for those on placement. This change of mind-set requires a paradigm shift in terms of nursing education and clinical practice experience for nursing students. Compliance and conformity are not the skills that need to be practiced during the clinical experience. Focusing on skills acquisition and nursing students being fit for purpose and practice must and should include an assessment of the suitability of the clinical learning environment, and whether it is ready to accommodate students as well as how students should be socialised into this environment. Acknowledging how nursing students are socialised into nursing throughout the trajectory of a career, and knowing its potential influence, are reasons to put strategies in place to ensure that nursing students on placement are included and feel included. Induction is important, but only addresses some of the problem. Encouraging staff to remember what it feels like to be new and unsure is also helpful. Disseminating information about the damage of being excluded, either wittingly or unwittingly, is also beneficial. It is clear that nursing students contribute to the ward whilst on placement, but there is an onus on the ward and its staff to contribute towards the nursing students' socialisation into the profession of nursing. It is possible that recognition of the socialisation process needs to be given through having a part of the clinical placement that is about socialisation rather than assessment. This could make the placement about questioning rather than conformity. This area of socialisation requires further research. Campbell (2003, p. 426) stated, in the conclusion of her study of

academic staff, clinical staff and nursing students, that the nurses of today need to assume responsibility for bringing those “*behind them with them*”, in order to sustain a positive future for nursing. Being aware of the importance of the socialisation process on the empowerment of nursing student is an important factor for preceptors and nurse leaders.

It would appear that the challenges as presented above, with the socialisation process for nursing students, have been somewhat ignored by academics and clinicians, while they continue to place nursing students in the clinical environment to learn how to practice and acquire the skills and attitudes associated with nursing. Fitting in and being and feeling part of the ward or unit was not easy for the participants (in all focus groups) in the present study. Nursing students found it an exhausting and difficult process to become socialised into a hospital/ward (section 4.4.1). Mackintosh (2006) highlighted that the socialisation process is more complex than earlier studies indicate, and that it varies considerably from individual to individual. There is a clear need to focus more on an individual approach to socialising nursing students into nursing during clinical placement in order to preserve empathy and compassion in the profession. The socialisation process incorporates inclusion and belonging of the nursing student while on placement, and the following sections discuss these topics in context, with the findings of the present study and other relevant literature.

5.4.1 Inclusion and belonging

In relation to the socialisation process into nursing, and the settling in period, many nursing students alluded to the difficulties of not being part of the team (Chapter 4, sections 4.4.1). Inclusion and involvement of the participants on the ward were pivotal to their sense of belonging. When staff included nursing students in the present study, they appreciated that they were part of the team. Including nursing students in the present study was often as simple as going to breaks with the preceptor or being made feel part of a team through simple gestures. These simple gestures however were important as Levett-Jones and Lathlean’s (2008) found that inclusion impacted nursing students through empowering them in their learning and eased the process of socialisation. A

similar finding was also reported in a contemporary study by Cooper et al. (2015) investigating the key influences of first year nursing students on placement. They found that students suffered as a direct result of the nursing culture, which was described as lacking in a sense of belonging, and that the key factor in the success of nursing students' placements lay in the relationship they formed with their key preceptor. The impact on the nursing student experience as a result of a poor relationship with nursing staff who do not promote a culture of inclusivity was marked in the Copper et al. (2015) study. This is perhaps due to the complexity of the clinical learning environment and its diversity from college and everyday life, which also contributes to the students' need to feel as though they belong, and therefore augments their need to be included. According to the nursing students in the present study, their inclusion in a ward environment fostered a sense of empowerment and promoted learning through experience (see section 4.4.1). The present study supports Newton et al. (2009), in an Australian study with a sample of six nursing students found that being accepted on the (nursing) team and becoming part of the team were essential parts of the socialisation process. The importance of having a support and inclusion are also highlighted by Bradbury-Jones et al. (2010), in that nursing students who have this positive experience are more likely to have a sense of empowerment.

5.4.2 Concluding thoughts on socialisation and empowerment

Current literature supports the importance of socialisation and inclusion in the clinical learning environment for nursing students (Dinmohammadi et al. 2013; Cooper et al., 2015). It is clear from the present study that the nursing students, although in their final year, were still struggling with the socialisation process. Indeed some authors have suggested that the socialisation process is life-long (Dinmohammadi et al. (2013). The most positive outcomes of socialisation into the nursing profession, according to Dinmohammadi et al. (2013), are: acquisition of professional identity, ability to cope with professional roles, and professional and organisational commitment, all of which contribute to improved patient care. It is therefore clear that the socialisation processes involved in undergraduate nursing students' education requires increased attention in the clinical learning

environment. How nursing students are socialised into the profession does matter, and may have life-long consequences for nursing, if not individuals. Nursing students outlined in the present study the challenges and difficulties associated in their socialisation into the profession of nursing, and also into the clinical learning environment. They described how being respected and trusted helped them. In addition, their need to be included and to feel as if they belonged in the clinical learning environment empowered their practice. Inclusiveness for the participants in the present study involved getting on with their preceptor and being accepted into the nursing culture. In fact, such is the importance of socialisation and inclusion that Baumeister et al. (2002) suggested that social exclusion impedes cognition, while Levett-Jones and Lathlean (2008) found that students are more empowered and available to learning opportunities when they felt part of the team and a sense of belonging. The findings of the present study concur with Levett-Jones and Lathlean's (2008) study, as the participants described how being included made them feel empowered in their learning (section 4.2.2), as well as improving their experience of socialisation into the clinical learning environment.

5.5 The influence of power, powerlessness on empowerment

Empowerment and power are difficult concepts to deal with in isolation from each other as each has a relationship with the other (Gilbert, 1995). Power is a part of empowerment and to understand one concept one must address the other. Chandler (1992) described power as being associated with control influence and domination (see section 2.4). Power can be seen and understood in observing how people or institutions (or in this case health care) are influenced, controlled and organised. Hierarchical power has long since been associated with nursing, from both an organisational and an educational perspective (Fletcher, 2006; Manojlovich, 2007). Fletcher (2006) argued that nurses need power and empowerment if they are to be capable of having the authority they need, to provide care and to influence the health of patients. Manojlovich (2007) supported this contention and stated that powerless nurses are ineffective as they are not able to influence patients and physicians. According to Benner (1984), the importance of empowerment in nursing is concerned with the ability of the nurse to

influence the health of the patient in a positive direction. In order to fully understand the influence of power on empowerment, Kuokkanen and Leino-kilpi (2000) proposed that power can be understood through drawing on three theoretical approaches namely: critical social theory, organisational and management theory and psychological theories. Bradbury-Jones et al. (2008) added a fourth perspective, known as post structuralism, and this concerns the work of Michel Foucault. The following section discusses power and powerlessness in relation to the findings of this study and other seminal literature using this framework.

5.5.1 Critical social theory perspective on power

Critical social theory, as discussed in section 2.5.3 is concerned with enabling those in subordinated positions to gain power and overcome domination (Bradbury-Jones et al. 2008). Empowerment in this context is viewed as liberating those who are oppressed (Kuokkanen & Leino-Kilpi, 2000). Critical social theory is based on the work of Freire (2000), who theorises that the oppressed internalise their oppressors' world view and make it their own (Bradbury-Jones et al., 2007b). Critical social theory is described by Mathews and Scott (2008) as an approach where oppressive social structures are maintained by the dominant. Mooney (2007) found evidence of conforming behaviours in her study of nursing students, where students reported adopting the attitudes and values of their preceptors in order to "fit in", when on placement. In the present study, nursing students described how they changed their personalities, becoming more like their preceptors, in order to be accepted and therefore socialised into the clinical learning environment (section 4.4.3). This supports Freire's theory of liberation pedagogy where the oppressed attempted to become like the oppressor, craving the power and control. Nursing students in the present study described the power process as being "*very one sided*" (section 4.3.1). In this process, they become marginalised and lack self-esteem and self-worth which can perpetuate the cycle further and result in behaviours that are characterised by horizontal violence or lateral violence (Fletcher, 2006; Bradbury-Jones et al., 2007b). Horizontal violence (HV) is defined by Thobaben (2007) as:

“...hostile, aggressive, and harmful behavior by a nurse or group of nurses toward a coworker or group of nurses via attitudes, actions, words and/or behaviors” (p. 82).

Horizontal violence is covert and difficult to discern frequently leaving the victims in a depressed state with lowered self-esteem (Becher & Visovsky, 2012). In the present study, these feelings of powerlessness and oppression were contributors to the disempowerment and powerlessness described by some participants. Roberts et al. (2009) argues that the lack of power in the clinical environment for nurses is endorsed by the hierarchical structures and the dominance of medicine over nursing for generations. For example, they suggest that the recruitment of nursing leaders/managers is frequently influenced by the powerful medical management therefore, perpetuating and promoting the hierarchy of power and the continuation of the feelings of powerlessness. This cyclical nature of powerlessness, oppression and low self-esteem impacts the culture in which the nursing students practice. Contemporary literature would indicate evidence of bullying in the clinical environment (Gillen et al., 2009); horizontal violence (Randle, 2003a); and disrespect to students (Daiki, 2004) as being prevalent. Nurse-to-nurse discrimination and oppression demonstrates the lack of empowerment and the presence of oppression in nursing according to Smith et al. (2010). Evidence from the present study suggests that the culture in the clinical learning environment for nursing students can be hierarchical and oppressive (section 4.5.2). Nursing students in the present study articulated feeling powerless and struggling to cope as they were ill prepared for dealing with it. The focus for nursing students became about coping and waiting for the programme to end rather than dealing with issues as they encountered them. Duchscher and Myrick (2008) suggest that a growing resentment festers and turns inwards when feelings such as these are not acknowledged and dealt with. The ultimate result they contend is that nurses will not be able to provide care to the standard to which they were educated (Duchscher and Myrick, 2008). This has repercussions: as Daiki (2004) described the pent up feelings of anger and frustration of nurses frequently leads to staff reacting in a hostile way, and furthermore contributes to feelings of disempowerment, while Becher and Visovsky (2012) acknowledge the long-term psychological damage horizontal violence may have on nurses. This was also experienced by nursing students in

the present study in the clinical learning environment (section 4.1.2). The findings of this study would suggest that nursing students are being socialised into an environment where many preceptors and qualified nurses feel powerless, which in turn results in the nursing students' feelings of powerlessness (section 4.3.3). The impact of this feeling of powerlessness and lack of esteem perpetuates in the profession. This is supported in the nursing literature as oppression theory suggests that powerlessness and low self-esteem contribute to HV and this can become a cyclical (St-Pierre & Holmes, 2008).

Fletcher (2006) suggested that lack of support for nurses from other nurses in the profession is because of the oppressive environment. This, Fletcher (2006) argued, leads to staff to being unable to provide the support for each other when required and this would include nursing students. However, the reasons why this is not possible, and does not occur, are, according to Fletcher (2006), associated with the experience of oppression. Laschinger et al. (2010b), in a study of 415 newly-qualified graduates, found that nurses' exposure to bullying is less prevalent in an empowering environment. This would support findings of the present study, where in one focus group (FG2) participants experienced empowerment and did not articulate an experience of hostility or incivility or powerlessness (section 4.3.2). Smith (2014) supported the development and aspiration of empowerment in education and practice through nurses being more respectful of each other, and advocated that individual differences are recognised and respected. Daiki (2004) maintained that through recognition of such behaviours and cultures in nursing, nurses can proactively change such disempowering behaviours. In contrast, the impact of powerlessness in nursing has been associated with poorer patient outcomes (Manojlovich & DeCicco (2007) and reduced job satisfaction (Manojlovich & Lashinger, 2002), while also rendering nurses more susceptible to burnout and depersonalisation (Leiter & Laschinger, 2006). The following section discusses how power is viewed at an organisational level in this study, as well as in contemporary research.

5.5.2 Power in the organisation

Laschinger's work is based on the premise that the following are key components of empowerment: power, access to information, support, opportunities and resources (section 2.5.1). This differs from critical social theory, as organisational theory is concerned with the distribution of power within an organisation. Laschinger et al. (2009) suggest that in order for an individual to feel powerful he/she will need access to the above components. The present study supports other nursing studies and literature (Kuokkanen & Leino-Kilpi, 2000; Peltomaa et al., 2013) in acknowledging the presence of hierarchical power at organisational and ward levels in health care (section 4.5). Organisational power in the healthcare setting typically occurs in a top-down configuration (Kuokkanen & Leino-Kipili, 2000). This type of hierarchical power is described in the present study in section 4.5. Communicating and/or reluctance to communicate with nursing management was viewed as a fear-inducing ordeal in the present study. The ensuing lack of communication with nursing managers may ultimately lead to a lack of information, support and resources, further compounding feelings of powerlessness and inadequacy. Hallett & Fealy (2009) and Barrow et al. (2011) supported the importance and relevance of nurses' power suggesting that despite the fact they are powerful in relation to health or care of an individual patient through their practice, they are often powerless in terms of the organisation. This appears paradoxical. However on closer examination it would appear that nurses are not politically strong enough within organisations to negotiate the institutional and organisational power structures, thus leaving a vacuum for others to fill and exert control over nursing and caring. This vacuum is more of a political vacuum, with many nurses asserting that they are too busy *doing*, rather than having time for the political negotiations that are required in large organisations. Nursing students in the present study supported the view that a hierarchical and traditional approach to power was experienced regularly while on placement (section 4.5). A concern from the present study is that nursing students' experience of power was of hierarchical and oppressive type of power. The following section details focus group 2, and how it differed from the other focus groups in relation to power.

5.5.3 Focus group 2 and power

Focus group 2 was an exception to the rule in regard to the participants' discussion on powerlessness. The nursing students in focus group 2 experience was different in this regard as hierarchical power was not discussed by the participants (section 4.1.2). A key criticism of the organisational theory approach to power is that power may not always be distributed in a top-down manner (Bradbury-Jones et al., 2008). Some organisations may not exert this type of power and may be more aware of the influence it can exert on those at the bottom of the hierarchy. This appeared to be the case with one hospital, as it was described by the nursing students of one focus group as being a supportive and positive environment (section 4.3.2) and nursing students in the study described a very empowering experience as a result. The factors that contributed to this appeared to be cultural, as described in previously in section 5.1. In addition, the nursing students described how they were socialised into the environment through inclusion and value increasing their self-worth, which in turn, contributed to their empowerment. The approach of management was more flattened, inclusive and visible, as was described in Chapter 4 (section 4.3.2), and this appeared to influence the experience of the nursing students in that their understanding of power was not hierarchical but rather a more flattened and inclusive. This contributed to the nursing students in focus group 2 having a very real and tangible sense of empowerment.

When empowerment was experienced by nursing students, it was interesting that powerlessness was not an issue raised by the participants. The reason for this difference is unclear. The impact of the nursing students being empowered was reflected in their discussion about patient care. The emphasis was on what they had the 'power' to do regarding to patient care, rather than the reverse. In focus group 2 nursing students did acknowledge that they had the power to impact care for their patients, which served to further their empowerment. This important point is supported in literature from (Manjlovich & Laschinger, 2002; Manojlovich, 2007). In addition literature supports that empowered nurses derive more satisfaction and meaning for their work which was also supported in the present study (Li et al., 2008; Ahmad & Oranye, 2010). This was strongly supported in the present study

despite the difficulties and challenges of learning and of the economic climate. Participants in focus group 2 were predominantly positive and presented an empowered and fulfilled description of their clinical experiences. This could be due to the positive culture experienced by participants, the socialisation process and the more visible nursing management as experienced by participants.

5.5.4 Post-structuralism theory of power

The work of Foucault is described in section 2.4. His work conceptualises power as being unlimited and unfixed, unlike organisational, critical social theory or psychological theory of power. He also acknowledges what it is that makes people crave power: i.e. it induces pleasure, forms knowledge and initiates discourse (Foucault, 1980). The post-structural approach is associated with the work of Foucault and is described by Bradbury-Jones et al. (2008) as concentrating more on the productive aspect of power than the repressive.

Mathews and Scott (2008) in an analysis of power and nursing in Ireland concluded that “disciplinary power” is pervasive and difficult to challenge. Within nursing, disciplinary power is evident through the standardisation of behaviour and the development of ritualistic practice, which may be used as a form of subtle coercion. This was evidenced in this study, when nursing students described doing anything the preceptor wished them to do and being anxious to please the preceptor. This type of non-questioning behaviour leads and encourages ritualistic practice. Interestingly, one of the traits of a profession is that professionals can practise autonomously (Manojlovich, 2007). Nurses’ autonomy to practise is often seen as dependent on the views of others within the multi-disciplinary team. Foucault’s (1980) theory of power suggested that powerless individuals actually have power in certain situations, and this can and should be exploited to optimum benefit. In relation to the findings of the present study, Foucault’s theory, if applied to the nursing students, would suggest that participants could view the power they have to change or challenge the ritualistic practices and status quo. This would then stimulate qualified staff to consider the care nursing students provide and their contribution and perspective. However, nursing students in the present study described not wanting to challenge the

status quo and appeared to be accepting of the elements of their placement they desired to change, in order to attain their qualifications (section 4.5). Foucault's theory on power acquisition and benefits can be seen when nursing students qualify and are aware of the danger that they may become like the qualified staff (section 4.3.2). This perpetuates the cycle of power and oppression and makes change difficult and less likely. However through the empowerment of nursing students they would become active and engaged as learners within the clinical learning environment developing and questioning practice which would hopefully continue as they register as qualified staff.

5.5.5 Psychological influences of power

Psychological theory of power focuses on the *individual's* experience of power. This is contingent on the individual person and his/her experiences in the past. Power, according to Chandler (1992), is exercised through relationships and social interactions (section 2.5). Within this context, the interpersonal relationship is individually contextualised. The psychological theory of power supports the importance of including the individual and his/her experiences in their future experiences in relation to power. Chandler (1992) viewed these social interactions as the source of power. The use of Layder's Social Domain Theory and Adaptive Theory in this study both complimented and facilitated the inclusion of the individual and his/her individual perspective (sections 3.4 and 3.5). In the present study, the acknowledgement of nursing students' experience of power within an organisation, and critically considering nursing students' conversations and reflections, support the inclusion and relevance of power in relationships. Some nursing students in the present study used their position (i.e. waiting for qualification) as a reason for their powerlessness (section 4.5). Acknowledging this, a concern arises as nursing students accept their lowly position within the hierarchy. However, this was not the case for all, as others were sufficiently empowered to feel powerful through their delivery of nursing care as was evident in focus group 2 (section 4.3.2). This is in keeping with Foucault's theory, where rather than assuming a position of powerlessness, the nurse is powerful in certain situations, mainly involving patients (section 2.5.4). The irony of the nurses' position is highlighted by Manojlovich (2007), when she described how the nurse

is closest in proximity to the patient (at the bedside) are probably furthest away in terms of distance from the decision-makers in the hospital. Peltomaa et al. (2013) supported the need for nurses to be involved in decision making and make more explicit their power and contribution in the organisation and management of hospitals.

Nugus et al. (2010) in an Australian study described the use of power by doctors and nurses as being competitive and collaborative on occasions. Doctors, Nugus et al. (2010) suggested, have been socialised into believing that they are the key decision makers for patient care. This reinforces a view held by some that nurses merely follow the instructions of the doctors, and are not significant in designing care plans or contributing to diagnosis of patients. Davies (2004) argued that this perception of the focus of nurses' work as being to augment that of doctors contributes to a political view of nursing. She suggests that this cultural unease about the quality of the work that nurses do is reflected in ambiguity in national policy and the lack of political direction of nurses as a group. This was reflected in the findings of the present study. It is important for all members of healthcare staff to recognise and respect all roles within a team. In referring to a nursing student as "the student" and not by name it can demonstrate a lack of respect and a lack of power in the role of learner. In addition, allocating direct patient care to those who have less experience is not conducive to teaching nursing students the importance of caring for the patient. Fletcher (2006) supported this contention and saw the value that is placed on technical jobs, rather than on caring, as evidence of this lack of value attributed to caring. Samson-Mojares (2014) suggested that the medical model's insistence on curing being of greater value than caring is demonstrated through the inclusion of the attending doctor's name over the bed, while the nurse who carries out the caring is un-named. Although it could be argued that such a demarcation of ownership is reductionist in terms of the importance of patient care, it is interesting to note that in this study nursing students did perceive direct patient care as a menial task. It is unclear whether this lack of value placed on patient care emerges from within nursing, or stems from a larger cultural influence (Davies, 2004). Within the present study when nursing students described empowerment in focus group 2 their focus and that of qualified staff was on patient care. It would appear that a hierarchical power

dimension and a lack of focus by staff on patient care are contributors to disempowering clinical learning environments and cultures. It is timely that this is addressed. If this remains unchallenged it will influence the importance that society and nursing places on those who provide care and will continue to diminish and undervalue the nursing profession but most importantly it influences patient care.

The impact of power and its influence on nursing students' empowerment was also evident in the present study in relation to the role of the preceptor (section 4.3 and 4.5). The role of the preceptor and the power the preceptor had considerable influence on the participants. It was clear from the present study that nursing students were empowered and learned from their preceptors, with one participant claiming that she learnt so much more on a placement when her preceptor was supportive. Forniers and Peden-McAlpine (2007) found, in a study of nursing students, that the student's critical thinking was directly influenced through the power dynamic between the student and the preceptor. This small American study (n=6) found that power and the role of the preceptor had a significant influence on nursing students' thought processes. This hierarchical power culture was found by Forniers and Peden-McAlpine (2007) to reinforce ritualistic rule as well as governed practice. Within this power dynamic between preceptor and student, change is difficult and, as the power is hierarchical, change is most likely to come from above. Nursing students quickly learn that they cannot effect change, and this further contributes to feelings of powerlessness. This can be seen in the present study (section 4.5), where nursing students describe keeping their heads down and accepting the *status quo*. It is possible, therefore, to bring about change, whereby preceptors need to be targeted and supported to impact change at ward level. This will have the effect of driving change up the hierarchy and also to nursing students, who will witness and experience the change. Staff are not powerless, and it is important that they do not perceive themselves in this way. In relation to this, and encouraging staff to take a proactive approach, Mathews and Scott (2008) advocate the harnessing of this power as being more constructive than adopting a powerless stance.

5.5.6 Concluding thoughts on power and its impact on empowerment

Overall concerns stemming from the present study, and supported by other studies (Daiki, 2004; Smith, 2014), is that nursing students are actively engaged in being and learning powerlessness in order to survive and pass assessments in the clinical learning environment. This consequently perpetuates the cycle of powerlessness. This cycle needs to be confronted openly through the empowerment of nursing students whilst on placement. This can be achieved through challenging and encouraging preceptors to be positive in their preceptorship, and through the provision of empowering and affirmative placement experiences and through dissemination of this research and others through education of preceptors and nursing managers. The hierarchical power dynamic needs to be exposed and openly discussed in academia and practice. Nursing students during their programmes need to be made aware of the risks of powerlessness and provided with strategies to empower them in their practice. The impact of disempowerment on the next generation may result in few being interested in becoming nurses and difficulties with retention of existing nurses. The power of providing care also needs to be given the attention it deserves at political level within the administration of hospitals and organisations.

5.6 Comment on clinical learning environment at the time of the study

The clinical environment is a challenging environment for students and staff and, according to contemporary research conducted across several European countries (Heinen et al., 2013), where burnout and exhaustion are common features of this type of environment. Work environment and relationship with work colleagues are identified as key predictors of nurses' intention to stay or return to work (Sjogern et al., 2005). Disempowerment was experienced by nursing students in this study as well as empowerment. Disempowering experiences were attributed by nursing students in the present study to the strain that preceptors and staff were under within the clinical learning environment (section 4.5). Some nursing students described a harsh and challenging environment in this study. Concurring with evidence from previous studies, this study would also support the contention that the clinical environment can be a hostile and challenging one

(Jackson et al., 2002; Duchscher & Myrick, 2008). Laschinger and her colleagues have developed a large body of knowledge that has explored the connection between how power, information, support, opportunity and resources are related to empowerment within organisations (section 2.5.1). Laschinger's (2008) study suggested that resources are a contributing factor to empowerment, or conversely disempowerment. In addition, Laschinger et al. (2001) found these concepts impacted commitment by nurses to their organisation or work.

Resources in this study did not appear to directly impact empowerment of nursing students. Nursing students, while they were aware of the limited fiscal resources and the harsh economic conditions, did not suggest that this impacted their empowerment directly, suggesting instead that being part of the team and feeling needed were significant factors to their empowerment (sections 4.3). However, it is possible that the staff as a result of these economic sanctions were under pressure during the timeframe of data collection for this study. Nursing students described how difficult work was for qualified staff who experienced wage cuts and staff shortages (section 4.5.5.). Nursing students did not blame staff for poor attitude or incivility when rather the nursing students empathised with the staff. They noted the staffs disempowerment and disillusionment and hoped that they would not become like them in the future. Within this environment the student as a learner was not always given a sense of priority regarding their learning experience due to the other pressures within the environment. It is interesting that just as the staff and the clinical learning environment did not place nursing students' experience to the forefront consequently nursing students did not either and so the focus for nursing students when they encountered disempowerment was to strive to circumvent it through rationalising it.

It is worthy of note that where a more supportive culture existed it appeared to protect and empower the nursing students (section 4.3.2). All hospitals were governed by the same organisation (HSE) and the same economic sanctions were imposed on each hospital. Yet some hospitals and more specifically wards/units offered a buffer in the form of empowerment against the harsh economic climate. This is an important finding of this study. In times of limited finances in health in the global economy, empowering staff is cost-effective way of exerting a positive

influence on the clinical learning environment, which will have resultant positive impact on staff retention and patient care. There are many potential reasons as to why Focus Group 2 presented such a stark contrast to the other focus groups. However perhaps focussing on 'why' focus group 2 was different is not as important as to note the difference- therefore it is possible that the salient point to bear in mind is that it was different. Empowered staff leaders and nurses impacted nursing students' empowerment and patient care positively. This is important because if one hospital can empower nursing students it means it can be replicated, repeated and encouraged. Nursing students reported in this study that culture, socialisation, preceptorship and power/powerlessness impacted their empowerment (Chapter 4). In section 4.3.3 feeling part of the team, never having to apologise for being a student, and seeing good practice were factors that students reported made them feel empowered. It is possible that these factors are sufficient to ensure that empowerment survives. This is especially important in times of economic crisis and distress. The requirement for staff and students to preserve and promote empowerment may be the sustaining factor. McDonald et al. (2016) suggested that building resilience and forewarning nursing students of the culture of incivility and hierarchical power in nursing is beneficial. McDonald et al (2016) suggested that nursing management must ensure staff and students are protected through acknowledgement of the impact of adversity and development of personal resilience. Price (2008) noted that recognising oneself in others is a major contributing factor to individuals' decisions to remain in nursing. In conclusion, Price (2009) encouraged nurses to be empathetic to each other, which will ultimately benefit the clinical environment, staff and nursing students and, perhaps most importantly, will benefit patient care.

5.7 Discussion of theoretical literature

This section presents the theoretical literature that has informed the study, in conjunction with the unique findings from this study. Within the literature on empowerment power is acknowledged as being an important element of the concept (Kuokkanen & Leino-Kilpi 2000; Manojlovich 2007). It is not possible to examine empowerment without acknowledging the influence of power (Kuokkanen et al., 2007). In Social Domain Theory, power is also acknowledged within the

social world, as the domains are interconnected through social relations of power which are also stretched over time and space. The discussion that follows identifies how each domain of Social Domain Theory relates to the empowerment of nursing students in this study, and demonstrates that no one level has analytical primacy over another. Each of the domains is layered to denote “ontological depth” and also to denote the difference between more personal domains and more remote domains.

Domain of psychobiography in relation to nursing students and empowerment

The domain of psychobiography is a personal domain that is concerned with an individual's life experiences from birth to the present day. This allows for individual experiences to be acknowledged as an influence in how a person will react to certain situations. Within this study, it was important to acknowledge that the nursing students' background, education and prior nursing experiences would be influential in how they interacted with preceptors on clinical placement. A previous study from Egypt (Ibrahim, 2011) found that students from rural backgrounds were more empowered than those from urban backgrounds. Layder (2004. p. 274) acknowledges that:

“every person responds differently to social experiences” (even shared ones).

This reinforces the importance of the individual's own perspective and experiences. Within this study, while there was a common perspective, there were also nursing students who held different views. All of these views were analysed and contributed to the findings of the study. For example, contradictory views of “feeling like a burden” and “being needed” are presented in section 4.3.2 and 4.5.2.

Layder (2006) suggests that individuals can live “inside” and “outside” society while retaining independence from “both” worlds. An example of this within the study was when the nursing students described changing their personality in order to “fit in” and be accepted into the ward or unit they were placed in. In nursing, many students felt the need to conform to expectations of them while on

placement. There are many examples of where individuals do not conform to societal norms despite socialisation process at play in the home, school or college. Layder (2006, p. 275) contends that this is:

“because we are unique, the fit between the individual and society is imprecise, imperfect and much more tenuous than most sociologists would allow”.

Research studies have shown where tensions exist between individuals and the profession, nursing students are frequently asked to leave the programme (Gilbert, 1995). This is evident in the study where nursing students discuss the fear of failing a clinical placement because of the lack of subjectivity or their inability to get on with preceptors (section 4.3). Gilbert (1995), in a review of the concept of power, noted that through the exertion of disciplinary power nursing students who are different, or who do not conform to the societal norms of the profession, are deemed “unsuitable” and fail. Therefore, through the domain of psychobiography Layder (2005) argued that, the individuals’ unique response to a set of circumstances can be traced synergistically with societal norms at a particular time. It is also important to note that through acknowledging the individual and also the societal expectations it provides a more accurate view of reality than ascribing to the notion that all individuals in society will respond in the same way. The following section considers the second domain of situated activity and the present study.

Domain of situated activity in relation to nursing students and empowerment

According to Layder (2005) the domain of situated activity is concerned with social interaction and where meaning in the interaction is recognised. Many theorists (for example symbolic integrationists, phenomenologists and ethnomethodologists) would concur with the concept that social interaction is the primary arena for the creation of meaning. Social Domain Theory, however, differs from these, as it views the social interaction as being more than a “social interaction” and views the psychobiography, or individual's prior experience, as a factor that warrants consideration within that social interaction. This view is not supported by phenomenologists and ethnomethodologists (Sibeon, 2004).

In relation to this study, the domain of situated activity allowed the nursing students to describe interactions that took place between themselves, the patients and the qualified staff. This was their individual “interpretation” of the interaction which involved incorporating the domain of psychobiography. Therefore, meaning is constructed through an amalgamation of subjective and objective experiences, as described by the nursing students (Layder, 2006). An example of this occurred during this study, when the nursing students said, “*they treat us as students*”, which technically would appear to be correct. However, on further inquiry, I discovered that the nursing students in this study felt that they were being used to provide basic care for patients, and this sometimes meant they missed learning opportunities on the ward/unit. When the nursing students used the word “students” in this study, they conveyed the meaning of lacking in worth, and feeling as though they were being used.

In order for successful communication to occur, each participant requires minimal levels of recognition, acceptance, inclusion and approval (Layder, 2006). In this study, there were many incidents of where students’ emotional needs were not being met by nursing/other staff in the clinical practice area, through lack of recognition paid to the nursing students or a lack of inclusion. One such example was when one participant (section 4.3.2) referred to the importance of being referred to by name and referred to the damage of disempowerment. Acknowledging this through the use of Layder’s Adaptive Theory (2006) and Social Domain Theory (2005) facilitated a deep understanding of the nursing students’ social interactions and their interpretations of them which, in turn, facilitated a deeper meaning of the concept of empowerment than would otherwise have been possible.

Domain of social activity in relation to nursing students and empowerment

Within the domains of social activity and contextual resources, the focus changes from subjective (domain of psychobiography and domain of situated activity) to the objectivity of the social space where the *activity* occurs. In this study, the social setting selected by the nursing students to participate in the focus groups is the clinical environment where students learn practical skills in nursing. This is also the place where the socialisation process occurs and the culture of nursing is

experienced. Culture, socialisation and historical legacy are all themes in this study. Using the clinical learning environment as the setting in this study was an important factor. The nursing students were in their uniforms as they participated in the study, since, in some cases, it formed part of their clinical day. This inclusion of the physical social space, i.e. the place where social interactions take place, refers to the clinical learning environment. The inclusion of the physical/social space demonstrates the depth that Social Domain Theory provides, facilitating the exploration of a complex phenomenon such as empowerment, whilst acknowledging the complexities of the multidimensional factors involved, including that of space and environment.

Domain of contextual resource in relation to nursing students and empowerment

The following sections outline the domain of contextual resources and explain its relevance in the present study.

Distributional aspect

The distributional aspect is concerned with material resources, such as distribution to race, ethnicity, age, gender and status. This encompasses social class education and background and how it affects an individual in a positive or negative way, depending on context. Within this study, for example, nursing students described their financial struggle to complete their nursing programme (see section 4.3.5) and some were single parents, and mature students while others were young college students (66% were under 25 years, see section 4.1. Table 4). All encountered empowerment from a different perspective, depending on the distributional aspect of their individual contextual resource.

Historical accumulation of cultural resources

This resource includes aspects such as morals, knowledge, media representations, and popular culture. In other words, it is the ultimate form of societal values. Within this study, nursing students spoke about “the pressures” that qualified staff are under. They described the current, pervasive culture in nursing, where staff described being under pressure due to staff shortages and the moratorium on recruitment (section 4.3). Social Domain Theory not only

allows for the inclusion of such ontological depth, but advocates that these influences affect the subjects in the study.

Connecting domains

In relation to the domains and the relationship between them, Layder (2006) cautioned that the domains of agency (psychobiography and situated activity) and the domains of structure (domains of social settings and contextual resources) are interconnected. However, for clarity they are described as discrete and separate entities. Each theme is not separate but connected and influenced by another.

Power and the domains of social theory

A key strength of Social Domain Theory is its inclusion and acknowledgement of power in the social world. Layder, in his Social Domain Theory (2006), views power as being present in each domain. The individual and inter-subjective forms of power are present in the domains of psychobiography and situated activity, whereas power in the objective domains (social settings and contextual resources) presents a different form of power. This power according to Layder (2006) is a reproduction of the social world and therefore is institutional, historical and entrenched. This had particular resonance within this study, as historical culture, legacy and power were themes that emerged from the initial literature review (Kuokkanen & Leino-Kilpi, 2000; DoH & C/DCU, 2003). Power in organisations, whether at macro, micro or meso levels, has evolved over time, and this is complimented by the individual (subjective) with the organisational (objective) domains in the methodology of this study. This is how Layder differs from Giddens and Foucault conceptualisation of power in that he views it as a “*multidimensional intermingling of forces*” (2006, p. 284).

This can be seen in the present study as power, for the nursing students was reflected through the nursing students’ relationship with their preceptor the person who could ultimately pass/fail the nursing student. However, behind the scenes, the organisational power was seen in the way some hospitals adopted a more flattened approach, rather than the traditional hierarchical approach. Nursing students described examples of how power in relationships was reinforced when they noted that they were asked to sit with their preceptors in some hospitals and

not in others. This demonstrates the stratified multidimensional ways in which power is communicated and evolves in organisations. It also reflects the impact that simple strategies of inclusion and belonging have on nursing students.

5.7.1. Concluding thoughts on theoretical literature influence on this study

In relation to this study, Adaptive Theory facilitates the exploration of empowerment at subjective (both individual and relational) and objective (structural and contextual resource) levels. It allows consideration for all levels, with no one level having analytical primacy. Adaptive Theory concerns itself with the diverse ways in which aspects of the lifeworld (behaviour, activity, day-to-day life) intersect with systemic aspects of the social world (culture, institutions, power, control, practices, social relations). The influences of the individual, the organisational and culture are threads throughout the study and all can be, and are, accommodated without being reduced or overshadowed by the other. The influence of Layder's work on this study is evident throughout. This chapter has sought to provide examples from the present study of where the literature and the findings complement and influence each other and also of the relevance of social domain and Adaptive Theory to the study. Layder's Social Domain Theory (2006) and Adaptive Theory (2005) provided a broad inclusive base facilitating the focus of the study on the organisation and on the individual at various stages during the study. Power as a contributory factor was also incorporated into the study through adaptive and Social Domain Theory's acknowledgement of its influence on individuals and society. The individual student and his/her story and experience was also acknowledged.

5.8 Chapter summary

Chapter 5 discussed the findings of the present study together with the theoretical and relevant literature. This study found that the contribution of culture to empowerment is significant and cannot be ignored. When the organisation/management or ward/unit culture was supportive staff were empowered and nursing students experienced empowerment. In addition

preceptors appear to be a key influence in ensuring that nursing students are being empowered while on clinical placement. Preceptors that are supported in their role are pivotal to ensuring that nursing students are facilitated in attaining the skills necessary to practice as empowered practitioners. However, if unrest and incivility within the clinical learning environment are not challenged these behaviours will continue to prevent the growth of empowerment amongst nursing students. Empowerment, critical thinking and creativity will be stifled in such environments. Academics and managers need to promote a zero tolerance to these behaviours within the clinical learning environment.

Socialising nursing students into the profession takes time and is a complex process. Increased awareness of encouraging inclusion, belonging and self-esteem is beneficial to the empowerment of nursing students. This can be facilitated through an assessment-free period within each student allocation to acknowledge the importance of socialisation. Nurses and nursing students need to recognise the power involved in the provision of care rather than positional power within the hierarchies of healthcare. Many nursing students described empowerment in this study however many also had an experience of disempowerment. Focus group 2 demonstrated that this does not have to be the case, illustrating the importance of the approach of the organisation and staff despite the challenges that abound in the current climate.

The following and final chapter draws conclusions from this study and suggests recommendations for future practice and research.

Chapter 6: Conclusion and Recommendations

6.0 Focus of the study

Chapter 5 discussed data from the present study in tandem with relevant seminal, contemporary and theoretical literature. Chapter 6 will consider the limitations of the study, draw conclusions from the findings and present recommendations for future practice, education and research.

The focus of this study was to explore empowerment of nursing students at the culmination of their programme in final year placement in a number of hospitals in Ireland. In order to explore and further understand this phenomenon, the following research questions were posed:

1. What do nursing students understand by empowerment?
2. What are the factors that impact empowerment development during final clinical placement in undergraduate nursing students?

Both questions were addressed by undertaking five focus groups to explore the concept of empowerment with nursing students in their final year placement whilst on a nursing programme in Ireland. Nursing students recognised the concepts of empowerment and disempowerment and had encountered both throughout the trajectory of their programme. They described what it was like to be empowered and the impact it had on them personally and professionally. Experiences of disempowerment were difficult for nursing students and provided challenges when encountered. The following section outlines the limitations of this study and reiterates the importance of empowerment (section 6.2) to nursing students in clinical practice. The final section (6.3) summarises the key findings and provides recommendations arising from this study for future practice and education. The chapter concludes with a final chapter summary.

6.1 Limitations of the study

It is important to acknowledge the limitations of this study. This study was conducted from one college in Ireland. In addition, although five focus group interviews were conducted, they were all conducted within the same cohort of nursing students, in the same college. It would be interesting to compare multiple sites. The lack of generalisability of the results is a limitation of the study as it cannot be assumed that other colleges and other students would feel the same way in relation to empowerment. However it does raise important issues regarding empowerment of nursing students in nursing education. In addition, it is evident from the volume of literature reviewed in Chapter 2 that empowerment is a topic of international relevance and it is possible that the findings will have relevance to other colleges and hospitals nationally and internationally. It is also acknowledged that some students that participated in the focus group interviews may not have been comfortable in discussing their personal experiences of empowerment or disempowerment in a group situation, or with me as a member of the academic staff. The following section highlights the key findings of the study with possible actions and recommendations for future practice.

6.2 Importance of empowerment

This study indicated that in order for nursing students to be empowered a climate of support is needed. Nursing management and preceptors impacted nursing students' sense of empowerment in clinical practice. It is vitally important that nursing students perceive themselves and those they provide care with as empowered clinicians. The positive influence of empowerment will improve patient care, and provide many benefits to the clinical learning environment. This study contributes to a growing body of knowledge testifying the challenges that exist within the clinical environment and presenting the possibilities of improvement through the adoption of an empowering approach. This opportunity to use empowerment to improve the experience of nursing students needs to be grasped. It is imperative that nurses in practice and academia work together to bring about change to empower nursing students which will improve the clinical learning environment for nursing students. Failure to address this issue will mean

that attrition of nurses and nursing shortages will continue as the system will continue to haemorrhage qualified staff. Exhausted, stressed and disempowered staff need to be supported within the healthcare system over the trajectory of their careers in order to sustain the perpetual demands on them.

6.3 Summary of key findings

The key findings of the study are presented in this section and the following sections revisit each one in more detail presenting recommendations for practice and possible actions. This study brings a new perspective on and understanding of, empowerment and disempowerment of nursing students during clinical placement. The influence of culture, positive preceptorship, socialisation and power/powerlessness experienced by nursing students in this study were key to whether nursing students experienced empowerment or disempowerment in clinical practice. Knowledge and acknowledgement of these factors can bring about changes in how nursing students experience clinical placement.

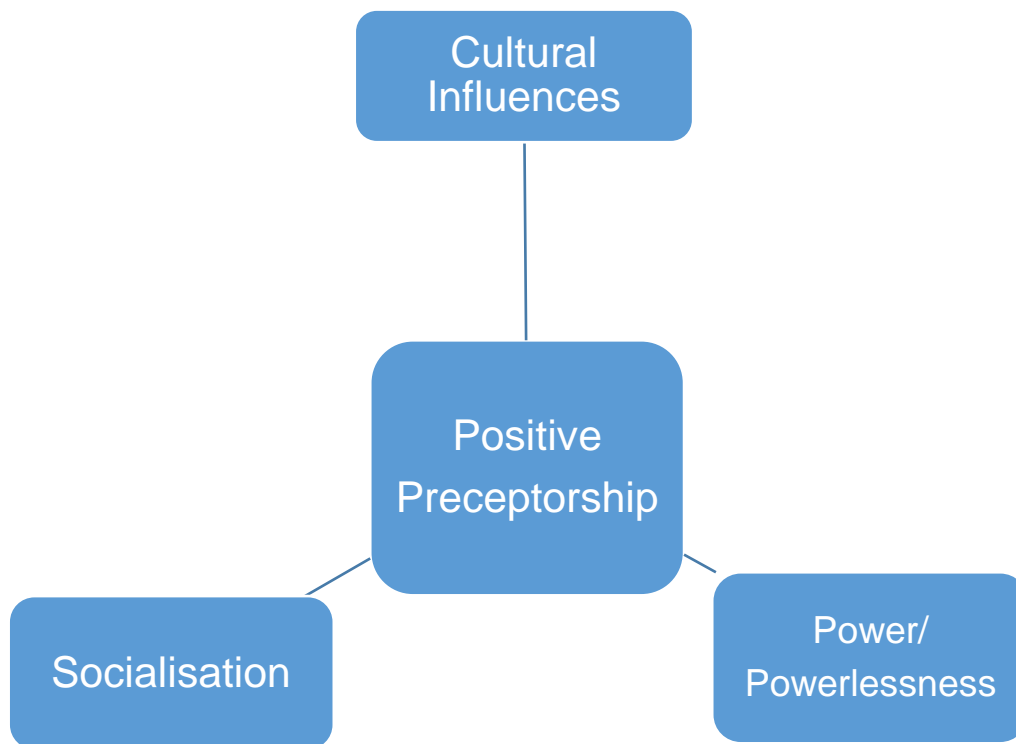


Figure 5: Key findings of the study

This study has indicated that certain elements of the clinical learning environment significantly impacted nursing student empowerment (see figure 5): Cultural influences, socialisation, positive preceptorship and power/powerlessness. Within the ward culture the preceptors (section 4.3.2) exerted a significant and important influence on empowerment and were the conduit through which nursing students experienced the ward/unit culture, socialisation and power or powerlessness. Once on placement nursing students started being socialised into the nursing profession, this process was challenging for many nursing students. Three distinct phases of socialisation were identified as: assimilation phase, appeasement phase and chameleon phase (section 4.4). Each phase of socialisation presented opportunities for preceptors to be cognisant of the empowerment opportunities for nursing students. Further research is warranted in this area to determine how to ease nursing students' transition into the nursing profession being aware of their desire to conform rather than challenge the existing status quo. Hierarchical

power was prevalent in this study and found to be disempowering and the threat of failure of clinical placement appears to further contribute to the powerful versus powerless dynamic experienced by some.

6.3.1 Cultural influences on empowerment of nursing student clinical practice

An important thread can be seen throughout this study. It appears that the gentle hand of history rests on the cultural legacy, throughout. Historical and cultural legacy are described in section 1.2 of this study and despite many changes in healthcare it is important to recognise that cultural change is perhaps more difficult and not very responsive to the passing of time. The cultural legacy is evidenced in this study in the nursing students' reluctance to blame those preceptors who do not treat them with respect, excusing those members of staff who behaved in anger (attributing it to economic climate or ward pressures) and putting up with such behaviours because they are nursing students. There was a lack of expectation on the part of the nursing students to be heard and to be valued for their contribution within the clinical learning environment. This demonstrated a lack of self-worth and assertiveness among nursing students in the study. If this lack of self-worth and empowerment remains unaddressed it will contribute to an environment where this becomes accepted and its contribution to a disempowered disenfranchised work force will have further ramifications for care and nursing education.

This is the first study on empowerment that has found culture as a major contributing factor in empowerment. Organisational/hospital and ward/units played a very important role in nursing student empowerment in this study. A variety of different experiences of culture were recounted by nursing students and, following a process of deep analysis (section 3.10), these have provided a clear vision of what the nursing students mean in terms of the provision of a supportive culture. The identified key aspects of culture that contribute to empowerment are that:

- Organisational culture needs to be less hierarchical and more flattened.
- Directors of Nursing and nursing managers' approach and attitude to nursing students on clinical placement are important and deserve attention.
- The visibility of nursing managers and their ability to make themselves present impacted nursing students' empowerment in this study.
- Awareness of the culture of nursing and the values espoused from staff to staff and staff to student suggested that a supportive culture needs to promote respect and inclusion.

The findings of this study would suggest that nursing culture warrants further examination in order to ascertain if these findings are generalizable within a broader population of nursing students. Nursing students are a valuable resource, and acknowledging the influence of culture on empowerment nursing leaders and academics need to be cognisant of its potential contribution to the educational experience of undergraduate nursing students. The findings of this study would support a reassertion of the value of culture in healthcare. The following recommendations would promote the inclusion of a positive culture to empower nursing students while on clinical placement:

Recommendations for practice and education

- In order to promote a more inclusive and supportive culture in hospitals, nursing managers need to embrace and acknowledge the important contribution nursing students make to the workforce. Staff interaction and efforts with nursing students' needs to be focused on an acknowledgement of the importance of the nursing students' contribution to the clinical learning environment.
- Incivility in healthcare whether colleague to colleague, or qualified nurse to nursing student, should not be tolerated, regardless of position.
- Respect and dignity policies should be adopted in all wards/organisation through a charter of communication in order to create an empowering and inclusive environment to provide nursing care in.

- Values and attitudes suitable and congruent with nursing ethos need to be reinforced by nursing managers and staff.
- Educational audit needs to focus on capturing what the values and attitudes that are espoused within a unit/ward culture.
- A culture of excellence needs to be encouraged in all activities and practices.
- Resources to investigate incivility and negativity within nursing culture are needed.
- Further education for preceptors and management on the importance of empowerment in culture is needed.

Nursing needs empowerment in order that innovation, creativity and compassion will become the cultural norm. If nursing students do not experience and witness these aptitudes, they will not learn or practice them in their nursing. Nurses are a finite human resource: they need to be nurtured in order to nurture others, and they need empowerment in order that others will experience empowerment. Nurses practice delivery of care in a challenging environment, where time pressure and stress are an everyday occurrence and a contributory factor in retention of staff (Heinen et al., 2013). It is therefore timely, as educators of nurses and preceptors, that we promote a more inclusive and supportive ethos within the clinical learning environment, in order to encourage the empowerment of nursing students.

6.3.2 Socialisation and its' impact on empowerment of nursing students in clinical practice

Socialisation (section 4.4) into the nursing profession was not easy for many nursing students in this study, who described how they struggled to be included and belong in the clinical learning environment. Nursing students articulated how they adapted and changed in order to gain acceptance and to be like those around them. Currently it is argued that assessment of nursing students' competencies on clinical placement while the student is struggling with the socialisation process does not give due recognition to the challenges of

socialisation. Through the socialisation process nursing students learn behaviours and learn quickly on placement to emulate these behaviours of their preceptors/role models. Staff need to be cognisant that caring behaviours are mirrored by nursing students, and failure to demonstrate caring and compassion to each other as staff is unacceptable. The behaviours that are needed to enable preceptors to provide a supportive socialisation into nursing while nursing students are on clinical placement are detailed throughout this study: Certain behaviours were described by nursing students in this study that ameliorated the socialisation process and made the process easier. Nursing students needed to be included, and a sense of belonging fostered, in order that they felt empowered during their time of clinical placement. This can be achieved by staff getting to know the nursing students, always referring to them by name, and including them with other staff on breaks from the ward and at meal times. Interpersonal relationships between nursing students and staff contributed to a sense of belonging, inclusion and self-worth. Nursing students described how they were socialised (section 4.4) and three distinct stages of the socialisation process (assimilation, appeasement and chameleon phases) were subsequently depicted during analysis of the data. The final phase it is postulated would be acceptance but students did not reach this stage during the time frame of data collection. The socialisation process highlighted many opportunities for empowerment through the nursing students recounting their experiences of empowerment and disempowerment in the present study. Preceptors need to be made aware of these steps in the process and their ability to positively influence the process of socialisation and consequently impact the empowerment process. The following recommendations for practice and preceptorship education would ameliorate the process of socialisation and ease the transition of the nursing student into the nursing profession:

Recommendations for practice and education

- Preceptorship education programmes and clinical updates need to emphasise the importance of socialisation (demonstrating the importance of fostering self-worth, inclusion and belonging) in the clinical learning environment to nursing students' empowerment.

- In order to promote the socialisation and inclusion of nursing students into the clinical environment respect and trust are essential.
- Inclusion and belonging can be promoted through the provision of: an inclusive and warm environment to welcome nursing students into. Spending time on induction for nursing students is an investment into the nursing students' education and time spent with nursing students reinforces their feeling of self-worth and belonging.
- An inclusive environment that fosters feelings of belonging (refer to nursing students by name).
- An appreciation of nursing student as team members and therefore inclusion into the team (breaks/meals).
- Time spent with nursing students to reinforce feelings of self-worth and empowerment (provides feedback on progress, point out areas for improvement).
- A less hierarchical approach to power within nursing management (by ensuring all members of the team are valued and this is a clear philosophy that is espoused to).
- Creative and critical thinking needs to be encouraged by a questioning approach from preceptors. Questioning tools and strategies should be implemented to encourage critical and analytical thought processes in nursing students.

The importance of socialising nursing students into an empowering and positive environment cannot be overstated. Evidence in the literature and the present study suggests that the clinical learning environment can sometimes be stifling and oppressive lacking encouragement for questioning and creativity. This can be intellectually restrictive and may, over time, stifle creativity, growth and energy. Learning needs to be prioritised and this can be achieved for the nursing students as learners if their focus is not on pleasing qualified staff in an attempt to belong, but rather on learning outcomes and learning from qualified staff and preceptors. The ramifications of a non-questioning and non-critical approach to nursing care abound in the many cases of poor practice in healthcare. Value on questioning and enquiry during placement will ensure that the clinical learning environment is a positive and open environment for learners. Patient care will improve in an

empowering environment, and evidence of this is provided in this study. It is time that honest and critical reflections of the environment into which nursing students are socialised should take place. Academics and clinicians need to bring about change through reinforcing the need to promote socialisation and empowered practitioners for nursing student education in clinical practice. By doing this nursing students will become empowered in their practice. The following section describes the specific impact of the preceptor on nursing student empowerment.

6.3.3 Positive preceptorship and its' impact on empowerment of nursing students in clinical practice

Preceptors served as role models to the nursing students in this study, exerting a tangible influence on nursing student empowerment. A positive finding of the study was that preceptorship was noted to be supportive, and this positively impacted the nursing students' sense of empowerment. When preceptors are empowered it means the nursing student will witness and emulate these behaviours and attitudes. However, preceptors require support in order to support nursing students as learners. It is possible that consideration by professional nursing boards could be given to incentivise those nurses who have a passion and interest in clinical teaching. Perhaps it is timely that the expectation that every nurse can support nursing students can be explored as the role of the preceptor encompasses a dual responsibility for both patient and nursing student. This makes the preceptor a person of considerable influence as a role model and assessor as well as practitioner. Perhaps the navigation of this dual role is too challenging for some preceptors. The following recommendation for practice and the education of preceptors will ensure that preceptors are recognised and empowered within their role:

Recommendations for practice and education

- Preceptors need to adopt an inclusive and open attitude to nursing students demonstrating awareness for the challenges of being a learner in the clinical learning environment.

- Facilitating preceptors with additional time for nursing students' assessments is needed.
- Nursing managers should be cognisant of the important role of the preceptor, and provide additional support to those who fulfil this role.
- A national study on the work load and lack of support available to preceptors is needed.
- Continuous dialogue between preceptors and academic staff within nursing colleges is needed to support the preceptor and ensure they are fulfilled within their role.
- Educational support, for preceptors are needed in order that they can sustain a positive and empowered approach and be effective and positive role models to support nursing students in the socialisation process.
- Dealing with challenges should be rewarded in the clinical environment, rather than encouraging compliance.
- Consideration should be given to qualified staff who are disengaged from a formal preceptorship role and recognition or rewards given to those that do have an interest in such a role.
- Leadership skills and updates should be made available to nurses and preceptors of all grades and not just those in management.

Evidence from this study would suggest that not acknowledging the difficulties and challenges in the preceptors' role leads to challenges for nursing student empowerment in clinical practice. Preceptors were reported as being under pressure on occasions and sometimes negative to nursing students demonstrating a lack of engagement or interest in teaching. Preceptors who display these types of behaviours require additional support. Nursing students however need a preceptor who is empowered and engaged in nursing student education in order to ensure an empowered future generation of nurses. In relation to nursing student learning the clinical learning environment should promote placements that provide opportunities for nursing students to witness critical thinkers and empowered practitioners. Preceptors should espouse the virtues and importance of critical thinking and learning. Creativity and critical thinking are not propagated in ground that is boggy with incivility and oppression. Creating space for preceptors that are interesting in teaching to role model and teach future

generations of nurses is vitally important to empowerment of nursing students into the future.

6.3.4 The impact of power /powerless on empowerment

Hierarchical environments stifle learning and facilitate cultures of poor practice. The Mid Staffordshire case highlights this in the disintegration of care from a systemic culture that was dysfunctional (Scott et al., 2014). Learning in the clinical learning environment needs to be given equal status and importance as learning in college. The power dynamic in clinical practice needs to be challenged and addressed through education and preceptorship programmes. Academics in nursing education need to promote empowerment of nursing students and acknowledge the difficulties that exist in the clinical environment for nursing students. A challenge for nursing is to embrace change and welcome a more flattened management approach. Nursing academics and managers need to show leadership in acknowledging what has to date been a hierarchical and on occasions stifling environment for nursing students.

Recommendations for practice and education

- Nursing students require preparation for clinical placement and to be informed of the challenges and power struggles that exist in a realistic and honest way.
- In an attempt to change hierarchical power in the clinical learning environment leaders and nursing managers need to be educated on the importance of adopting a more flattened and less hierarchical system.
- Reform of the clinical nursing environment is needed and student placement should be contingent on the environment's ability to address this reform.
- The self-esteem of qualified staff needs to be nurtured through respect and dignity in all communication with all team members (including nursing students).

- There should be a zero tolerance approach to incivility and bullying in the work place.
- Essential patient care should not be delegated to those with the least experience.
- Nursing curricula should include empowerment promoting and building strategies.
- Modules on dealing with incivility in the workplace to include negative behaviours and promotion of assertiveness are needed in nursing curricula.

Chapter 1 of this thesis provided a brief insight into the evolution of nursing, specifically in an Irish context. The quest for professionalization was discussed and literature on power and empowerment was evaluated in section 1.7.5. However, despite the vast amount that has been written to provide context and understanding, from Foucault to Freire, it remains unclear if nurses really do understand the power they possess when providing care. Assigning the intimate care of sick patients to novice/learners is worthy of consideration. Does this mean that this is the most important function or role of the nurse, or the least? What message does this convey to the learner? The nursing students in the present study appeared to be powerless as they embarked on the final placement of their nursing programme. A reluctance to be assertive was described and lack of knowledge of power, or the students' personal power as learners, was also evident. The students' demarcation of their status through the wearing of "red stripes" further reinforced their opinion of their lowly status. The importance of educators and clinicians claiming power as professionals and experts in patient care is essential to empowering the nurses of the future. The power in caring needs to be made visible and tangible within the management structures of hospitals thus empowering nurses in their provision of care.

6.4 Final chapter summary

The clinical learning environment needs to foster an empowerment informed practice amongst nurses of the future that develop critical and creative new ways of thinking and doing. The findings of this study suggest that empowerment can be and is experienced by some nursing students on clinical placement. The factors associated with empowerment were clearly described by participants in the study and are identified as:

- A culture of support
- Support during the socialisation of nursing students to a new ward/unit/hospital/organisation
- Positive preceptorship
- Less hierarchical approach by nursing management to patient care

In these environments and cultures empowerment flourished (focus group 2).

However, this is not the case for all nursing students or in all placements. It is clear from this study that some nursing students experienced disempowerment while on clinical placement. The damage of disempowerment was articulated and visible in some of the nursing students' contributions. This should be of concern to clinicians, academics and nurses in general.

A culture and climate where empowerment can be propagated is needed now more than ever due to the challenges in healthcare. Behaviours such as incivility, hierarchical power differentials, lack of a supportive culture and socialisation processes that did not make students feel part of the ward/unit were components that disempowered the nursing student. In such environments there appeared to be a cyclical culture of disempowerment between qualified nurses and nursing students.

The findings of this study would suggest that breaking this cycle of disempowerment within the clinical placement experience will not only foster better nurses but also better nursing care. The recommendations of this study

would suggest that the experience of empowering nursing students through their clinical placements, though difficult to implement, is a necessary and a worthwhile endeavour in order to address the demands involved in the education of nursing students and the delivery of nursing care

Appendix 1 - Written Information for nursing students

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Dear Nursing Student

I am in year 3 of a PhD study in nursing with University of Salford Manchester. My area of research is exploring the concept of empowerment of nursing students during final year clinical placement. There is little available in current literature on this subject. I hope to explore this from the student's perspective the use of focus groups. It is envisaged that this study will inform future curricula and the education of nursing students through recognizing the ways that nursing students are empowered/ disempowered whilst on clinical practice. Ethical approval has been granted by the Research Ethics Committee, XXX for this study. I have obtained permission to conduct this study from the Head of Department and Directors of Nursing in the region.

Please find enclosed an information sheet which outlines details of the project. Please **read and consider** the enclosed information carefully. If you are interested in participating in the research project please indicate this by signing the enclosed sheet and placing it the tray at the porters' desk in the nursing building. A further meeting to complete the consent form will be held at a later date should you wish to participate. Telephone numbers and email are provided below if you wish to contact me with questions.

Yours sincerely

Sara Kennedy
General Nursing Lecturer
051/845543 or 0872043644
Email: spkennedy@wit.ie

Appendix 2 - Consent Form

Research Study: The impact of clinical placement on adult nursing students' perceptions of empowerment in Ireland.

Name of Investigator: Sara Kennedy

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and had these questions answered satisfactorily
2. I understand that my participation is voluntary and that I am free to withdraw at anytime, without giving any reason and without any future comeback
3. I confirm that I have read the above and agree to take part in this research study
4. I am aware that the interviews will be taped using audio taping.
5. I am aware that my identity will be protected in this research study and in the dissemination and any future publications from this study.
6. I agree to participate in the focus groups as part of this study.

Participant Signature..... Date.....

Name (in block capitals).....

I have explained the study to the above participant and he/she has indicated his/her willingness to take part.

Investigator Signature..... Date.....

Appendix 3 - Letter of Ethical Approval



Research, Innovation and Academic
Engagement Ethical Approval Panel

College of Health & Social Care
AD 101 Allerton Building
University of Salford
M6 6PU

T +44(0)161 295 7016
r.shuttleworth@salford.ac.uk

www.salford.ac.uk/

11 July 2012

Dear Sara,

RE: ETHICS APPLICATION HSCR12/37 – The impact of clinical placement on adult nursing students' perceptions of empowerment in Ireland

Following your responses to the Panel's queries, based on the information you provided, I am pleased to inform you that application HSCR12/37 has now been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth
College Support Officer (R&I)

Appendix 4 - Letter to Directors of Nursing

Institiúid Teicneolaíochta Phort Láirge

Waterford Institute of Technology

Port Láirge, Éire.
T: +353-51-302000
info@wit.ie

Waterford, Ireland.
T: +353-51-302000
www.wit.ie



Xxxxx
Xxxxx

Xxxxxx
Xxxxxx
xxxxxx

Dear X

I am in year 3 of a PhD study in nursing with University of Salford Manchester. My area of research is exploring the concept of empowerment of nursing students during final year clinical placement. I hope to explore this from the student's perspective through focus group with nursing students.

Ethical approval has been granted by the Research Ethics Committee, HSE, South East; Salford University Ethics Committee and Waterford Institute of Technology Ethics Committee. I am writing to request permission to access students for the purpose of attending a pre-arranged focus group. Confidentiality and anonymity of all the participants will be safe-guarded and strict adherence to the ethical principles of research is assured at all times. I am available to discuss the proposal and answer any queries and issues that arise.

Yours Sincerely

Sara Kennedy

Appendix 5 - Focus Group Schedule

Focus Group Schedule

- Introductions
- Housekeeping, beverages, length of time, confidentiality reiterated, right to withdraw, consent
- Informing participants regarding outline of the focus group
- Prompts below will facilitate further discussion on empowerment (from current literature)

1. What does the term empowerment mean to you?

Prompts:

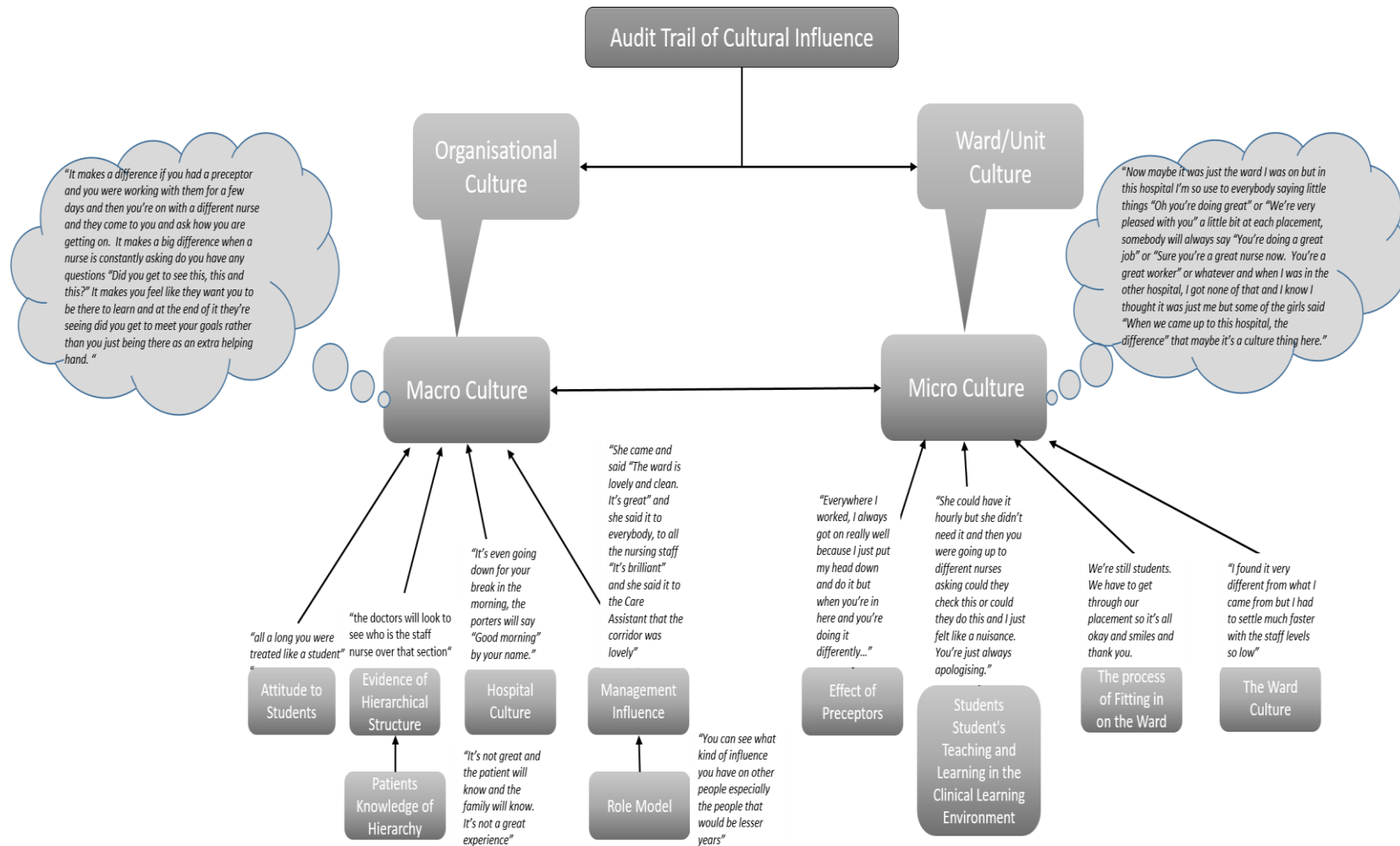
Being valued; being an advocate; Scope of practice; Competence; Skills; Access to resources; Supportive management; Being provided with opportunities; Being provided with relevant information within the organisation; Being perceived as powerful; Feeling powerful within my role.

2. What impacts your feelings of empowerment?

Prompts: Meaning of Job; Confidence to do my job; Autonomy within my role; Impact I have within the organisation; Does being listened to impact your level of empowerment? Being listened to by members of multidisciplinary team; being recognised as a professional by members of the medical profession

3. Do you feel empowered in your role?
4. What makes you feel empowered?
5. What makes you feel disempowered?
6. What are the ways in which you in your role could be made feel more empowered?
7. Do you value empowerment?
8. Are there any benefits to you as an individual to being empowered at work?
9. Are there any benefits to the patients if you are empowered at work?
10. Can you provide an example of an empowering experience within a work context?
11. What did it feel like to be empowered?
12. Any other comments on your views on empowerment?

Appendix 6 Mind map of audit trail of cultural influences



Appendix 7- Coding Book

Step 2 Pre-coding - 28 Initial Broad Participant Led Codes			
Code	Code Definition (rule for inclusion)	Focus Groups Coded	Unit of Meaning Coded
Attitude to students	How does the preceptors' attitude to students impact the students' ability to be empowered?	4	121
Benefits of Empowerment	What does it mean to be empowered	5	115
Communication	Effect of communication on empowerment	5	43
Competence	Factors influencing empowerment	5	17
Confidence	Factors attributed to being empowered	5	116
Culture	How does culture impact empowerment	4	69
Disempowering Preceptors	Factors that disempowered nursing students	5	100
Doctors Impact	Do doctors impact the empowerment/disempowerment process?	4	9
Effect of Preceptors	The effect of preceptors on students ability to perform	5	126
Experience	Effect of experience on empowerment	2	10
Job Satisfaction	By product of empowerment	5	45
Level in the programme	Is empowerment different at different levels of programme	5	30
Organisational Benefits to Empowerment	What are the organisational benefits to empowerment	3	9
Patient influence on empowerment	Does the patient feedback influence your level of empowerment	2	10
Power	Power and how it contributes to empowerment or disempowerment	5	45
Process of Empowerment	How does empowerment occur in internship?	5	131
Relationships	Effects of relationships on empowerment /disempowerment	5	81
Respect	Respect as a contributor to empowerment	5	29
Responsibility	Factors contributing to empowerment	5	36
Security	Level of security contributes to empowerment	3	3
Socialisation	How do the students become socialised into their new environment	4	57
Staff Morale	How does staff morale affect empowerment or disempowerment?	4	32
Stress in environment	How does the stress in the environment contribute to empowerment or disempowerment	4	48
Support	Factors contributing to empowerment	5	35
Team Player	Does belonging in a team affect empowerment	3	22
Trust	The impact of trust in the development of empowerment and disempowerment	4	15
What does it mean to patients if student nurse is empowered	Explanation of what it means to be empowered	5	53
What is disempowerment	Contributing Factors of disempowerment	5	68

Step 3 Provisional Coding			
Categories and Re-organised Codes	Code Definitions (Rules for Inclusion)	Focus Groups Coded	Units of Meaning Coded
Benefit to the nursing student of Empowerment	What are the benefits to the nursing student of being empowered	5	41
Job Satisfaction	By product of empowerment	5	48
Benefit to the Patient of an Empowered Nurse	What are the benefits to the patient of the nursing student of being empowered	4	14
Meaning of Empowerment to Nursing Students	What meaning do the nursing students give to empowerment	5	31
Nursing Students Perspective on themselves	How do they view themselves	4	7
Organisational Benefits to Empowerment	What are the organisational benefits to empowerment	3	13
Competence	Factors influencing empowerment	5	22
Confidence	Factors attributed to being empowered	5	124
Management Influence	How do managers influence empowerment	4	35
Role Model	The importance of a positive role model as viewed by the nursing students	2	5
Recognition = Respect, Value and Appreciation	Respect as a contributor to empowerment	5	16
Recognition and Appreciation from Patients	How does the recognition and appreciation of patients and relatives impact empowerment of nursing students	1	1
Relationships	Effects of relationships on empowerment /disempowerment	5	85
Communication	Effect of communication on empowerment	5	43
Responsibility	Factors contributing to empowerment	5	45
Stress in environment	How does the stress in the environment contribute to empowerment or disempowerment	0	0
Coping with Stressful Environment	How do the nursing students cope with the stressful environment	3	8
The Ward Culture	How does each individual ward culture contribute to nursing students empowerment	2	8
External Stressors in the environment	What are the external stressors in the environment that impact students empowerment	3	24
Lack of Time		1	4
Stress from qualified staff	Does the stress of staff impact nursing students empowerment	1	3
Internal Stressors	What are the internal stressors that impact nursing students empowerment in the ward or hospital	4	11
What next	Where to next end of the road	1	2
Support	Factors contributing to empowerment	5	41
Lack of support	Lack of support to the nursing students that impacts their empowerment	1	2
Team Player	Does belonging in a team affect empowerment	5	34
Culture	How does culture impact empowerment	0	0
Patients knowledge of hierarchy	Is there evidence that the patient is aware of the hierarchy	1	1
Macro Organisational Culture	Individual atmospheres and cultures associated with different placements	3	18

Step 3 Provisional Coding			
Categories and Re-organised Codes	Code Definitions (Rules for Inclusion)	Focus Groups Coded	Units of Meaning Coded
Hospital Culture	How does the organisational culture contribute to nursing students empowerment	3	11
Staff Morale	How does staff morale affect empowerment or disempowerment?	2	18
Micro Ward Culture	Included in this is the individual ward, unit, staff and atmosphere of placement area	4	22
Attitude to students	How does the placement and preceptors & attitudes to students impact the students ability to be empowered?	5	132
Students Teaching and Learning in the Clinical Learning Environment	Evidence of staffs interest in teaching students that is empowering	2	6
Feedback	Preceptors providing feedback to nursing students	5	15
Level in the programme	Is empowerment different at different levels of programme	4	7
Poor treatment of nursing students	Evidence of poor treatment of nursing students by other staff	1	1
Students feeling they are being used	Nursing students being treated poorly	3	10
The Doctors Impact	Do doctors impact the empowerment/disempowerment process?	4	9
Trust	The impact of trust in the development of empowerment and disempowerment	4	12
Dis- trusting attitude to nursing students		0	0
Effect of Preceptors	The effect of preceptors on students ability to perform	5	130
The process of fitting in on the ward	How do nursing students fit in on the wards and clinical areas?	3	32
Disempowering Preceptors	Factors that disempowered nursing students	5	104
What is disempowerment	Contributing factors of disempowerment	5	85
Power	Power and how it contributes to empowerment or disempowerment	4	55
Evidence of Hierarchical Structures and Attitudes	Evidence of hierarchical values adopted by students in relation to their status and status of others	4	17
Personalities and Relationships	The effect of personalities and relationships on the students empowerment	4	15

Step 4 Developing Themes			
Category 1 - Cultural Factors Contributing to Empowerment or Disempowerment		5	470
Macro Organisational Culture	Individual atmospheres and cultures associated with different placements	4	30
Hospital Culture	How does the organisational culture contribute to nursing students empowerment	3	11
The Ward Culture	How does each individual ward culture contribute to nursing students empowerment	2	8
Micro Culture	Included in this is the individual ward, unit, staff and atmosphere of placement area	4	22
Recognition = Respect, Value and Appreciation	Respect as a contributor to empowerment	5	16
Effect of Preceptors	The effect of preceptors on students ability to perform	5	130
Communication	Effect of communication on empowerment	5	43
Responsibility	Responsibility in the clinical learning environment	5	45
Category 2 - Socialisation Process	How are the nursing students socialised into practice	4	89
Relationships	How to fit in on placement	5	85
Staff Morale	Impact of staff morale and affect empowerment or disempowerment?	2	18
The process of fitting in on the ward	How do the nursing students fit in to the environment	3	32
Attitude to students	How do the preceptors attitudes to students impact the students' ability to fit in?	5	132
Communication	Communicating with preceptors and staff	5	43
Role Model	Positive role model as viewed by the nursing students	2	5
Category 3 - Power		5	55
Power	Power and how it contributes to empowerment or disempowerment	5	55
Evidence of Hierarchical Structures and Attitudes	Evidence of hierarchical values adopted by students in relation to their status and status of others	4	17
Staff Morale	How does staff morale affect empowerment or disempowerment?	2	18
What is disempowerment	Contributing Factors of disempowerment	5	85
Disempowering Preceptors	Factors that disempowered nursing students	5	104
Staff Morale	How does staff morale affect empowerment or disempowerment?	2	18

Step 5 Refinement of themes and categories	
Name	Description
Theme 1: Cultural Influences Organisational Culture Ward/Unit Culture	The cultural influences are subdivided into organisational (hospital) and ward/unit culture.
Theme 2: Socialisation Process Assimilating Phase Appeasement Phase Chameleon Phase	How are the nursing students socialised into practice
Theme 3: Power / Powerlessness Status quo Drowning in disempowerment Fear of failure Clinical learning environment and context at time of the study	How did participants experience power and powerlessness

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